

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN lb 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 21217 d. STREET ADDRESS 2318 BRYANT STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALBERT Middle - Last AARON		4. DATE OF DEATH Month DECEMBER Day 20 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/1905
9. AGE (In years th/day) 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	
11. BIRTHPLACE (County & State, or foreign country) GREENWOOD, SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR AARON		14. MOTHER'S MAIDEN NAME NANCY MINION	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 213 07 20 63	
17. INFORMANT CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BENIGN PROSTATIC HYPERTROPHY		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 12/18/67 , 19 67 , to 12/20/67 , 19 67 , that (2) (we) last saw the deceased alive on 12/20/67 , 19 67 , and that death occurred at 6:15A M, from causes and on the date stated above.			
22a. SIGNATURE John D. Talbert		22b. DATE SIGNED 12/20/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12-26-67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR MORTEN & DYETT FUNERAL HOME		25a. REC'D BY REGISTRAR DEC 21 1967	
ADDRESS LAURENS ST. BALTIMORE, MD.		25b. REGISTRAR'S SIGNATURE John D. Talbert	

UNITED STATES

DEPARTMENT OF JUSTICE

INVESTIGATION

OF THE

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CERTIFICATE OF DEATH

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16424

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY HALL		c. LENGTH OF STAY IN lb 1 YR.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4134 BROOKFIELD RD				d. STREET ADDRESS 3227 KENYON AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JEPHTHA Middle ABBOTT Last ABBOTT				4. DATE OF DEATH Month DEC Day 28 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 4 1895	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ESTIMATOR		10b. KIND OF BUSINESS OR INDUSTRY BALTO GAST/ELEC.		11. BIRTHPLACE (County & State, or foreign country) PASSAIC N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN ABBOTT				14. MOTHER'S MAIDEN NAME ROSE McMANUS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 212-05-4000		17. INFORMANT Address WILLIAM CARTER 4134 BROOKFIELD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Acute myocardial degeneration. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Coronary Arteriosclerosis. DUE TO Generalized Arteriosclerosis.							INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 10 yrs. 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from July , 19 57 , to 12/28 , 19 67 that (I) (we) last saw the deceased alive on Dec. 21 , 19 67 , and that death occurred at 9:30 A.M. , from causes and on the date stated above.							
22a. SIGNATURE Theodore E. Evans				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/28/67	
22c. PHYSICIAN'S NAME (Type) THEODORE E. EVANS M.D.				22d. ADDRESS 9660 BELAIR RD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/30/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CFM.		23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
24. FUNERAL DIRECTOR THE DIPPEL BROS INC				ADDRESS 7110 BELAIR RD		25a. REC'D BY REGISTRAR JAN 2 1968	
				25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
20M 1/65

16434
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MD
16425
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Holbrook</u>		c. LENGTH OF STAY IN 1b <u>13-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CHARLIE HILL Nursing Home</u>		d. STREET ADDRESS <u>CLARKSVILLE PIKE</u>	
3. NAME OF DECEASED (Type or print) <u>Charles W. Anderson</u>		4. DATE OF DEATH <u>DEC 21 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>TENN.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>MELVIN J. Anderson</u>		14. MOTHER'S MAIDEN NAME <u>MARY ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>M. J. Anderson</u>		Address <u>HANOVER, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Detachment of Heart</u> 4214 DUE TO (b) <u>Cor. Valv. Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. E. Martin</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wm. E. Martin</u>		22d. ADDRESS <u>Randallstown Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-24-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CRESSLAWN</u>		23d. LOCATION (City, town or county) (State) <u>W. FRIENDSHIP Md.</u>	
24. FUNERAL DIRECTOR <u>Higginbotham-Black</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Elliot City, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>DEC 27 1967</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18&21 Film 397
2-7-68 ams

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16426

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 1655 E. Northern Parkway	
3. NAME OF DECEASED (Type or print) CATHERINE (RENA) M. ARMSTRONG		4. DATE OF DEATH Month December Day 27 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/1/05
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John A. Forster		14. MOTHER'S MAIDEN NAME Barbara Fichtner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Edwin M. Armstrong, husband, above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3220 IMMEDIATE CAUSE (a) Cerebral hypoxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Shock probably secondary to acute ethylism DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED December 28, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/67	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. REC'D BY REGISTRAR DEC 29 1967	
25b. REGISTRAR'S SIGNATURE Judge			

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16436

16427

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN lb 39 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODSBORO d. STREET ADDRESS 10-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH First Middle Last M. ARNOLD		4. DATE OF DEATH Month Day Year DEC. 24 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1884
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY NO	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME GEORGE KNELL		14. MOTHER'S MAIDEN NAME SOPHIE WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-16-2963	
17. INFORMANT Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMO PERICARDIUM, E TAMPONADE DUE TO RUPTURE OF L. VENTRICULAR MYOCARDIAL INFARCT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE (c) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour : o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) P.P.	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-13 , 19 67 , to 12-24 , 19 67 , that (I) (we) last saw the deceased alive on 12-24 19 67 , and that death occurred at 9:40 AM , from causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 12/24/67	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/27/67	23c. NAME OF CEMETERY OR CREMATORY Rocky Hill Cem.	23d. LOCATION (City or Town) (County) (State) FREDERICK COUNTY MD
24. FUNERAL DIRECTOR Cowell & Fairley		25a. REC'D BY REGISTRAR WOODSBORO MD	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 28 1967	

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Washington

Mount Wilson

Mount Wilson State Hospital

Mount Wilson State Hospital

W. H. Newcomb, M.D., Superintendent Mount Wilson, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16437

16428

1. DECEASED-NAME (Type or print) First: <u>Dora</u> Middle: <u>Lindsay</u> Last: <u>Ayres</u>			2a. DATE OF DEATH Month: <u>Dec.</u> Day: <u>25</u> Year: <u>1967</u>		2b. HOUR M: <u></u>
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>Nov. 24, 1887</u>		6. AGE (In years lost birthday) <u>80</u> YRS.	IF UNDER 1 YEAR MONTHS: <u></u> DAYS: <u></u>
7a. BIRTHPLACE (State or foreign country) <u>Wil. Delaware</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <u>Baltimore</u>			Md.		
10. CITY OR TOWN OF DEATH <u>Pikesville</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>1018 Windsor Rd., Pikesville</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Baltimore</u>	13c. CITY OR TOWN <u>Pikesville</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <u>1018 Windsor Rd., Pikesville</u>
14. FATHER'S NAME First: <u>William</u> Middle: <u>Lindsay</u> Last: <u></u>			15. MOTHER'S MAIDEN NAME First: <u>Mary</u> Middle: <u></u> Last: <u>Starling</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. William J. Reed, 1018 Windsor Rd., Pikesville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> <u>4200</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>BILATERAL BASILAR PNEUMONIA</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-22-67</u> to <u>12-23-67</u> , that (I) was saw the deceased alive on <u>12-22-67</u> , and that in (my) my opinion death occurred on the date and hour and from the causes stated above, (I) was did (did not) view the body after death.					
22b. SIGNATURE <u>Samuel P. Scaglia, M.D.</u>		22c. DATE SIGNED <u>12-27-67</u>		22d. PHYSICIAN'S NAME (Type) <u>SAMUEL P. SCAGLIA, M.D.</u>	
22e. ADDRESS <u>2 SHERRWOOD AVENUE PIKESVILLE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 27, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Pikesville Baltimore Md.</u>					
24. FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville, Md.</u>		25. REC'D BY REGISTRAR <u>JAN 4 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, it should be directed to the Deputy Medical Examiner, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director for Pages 4 and 5. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

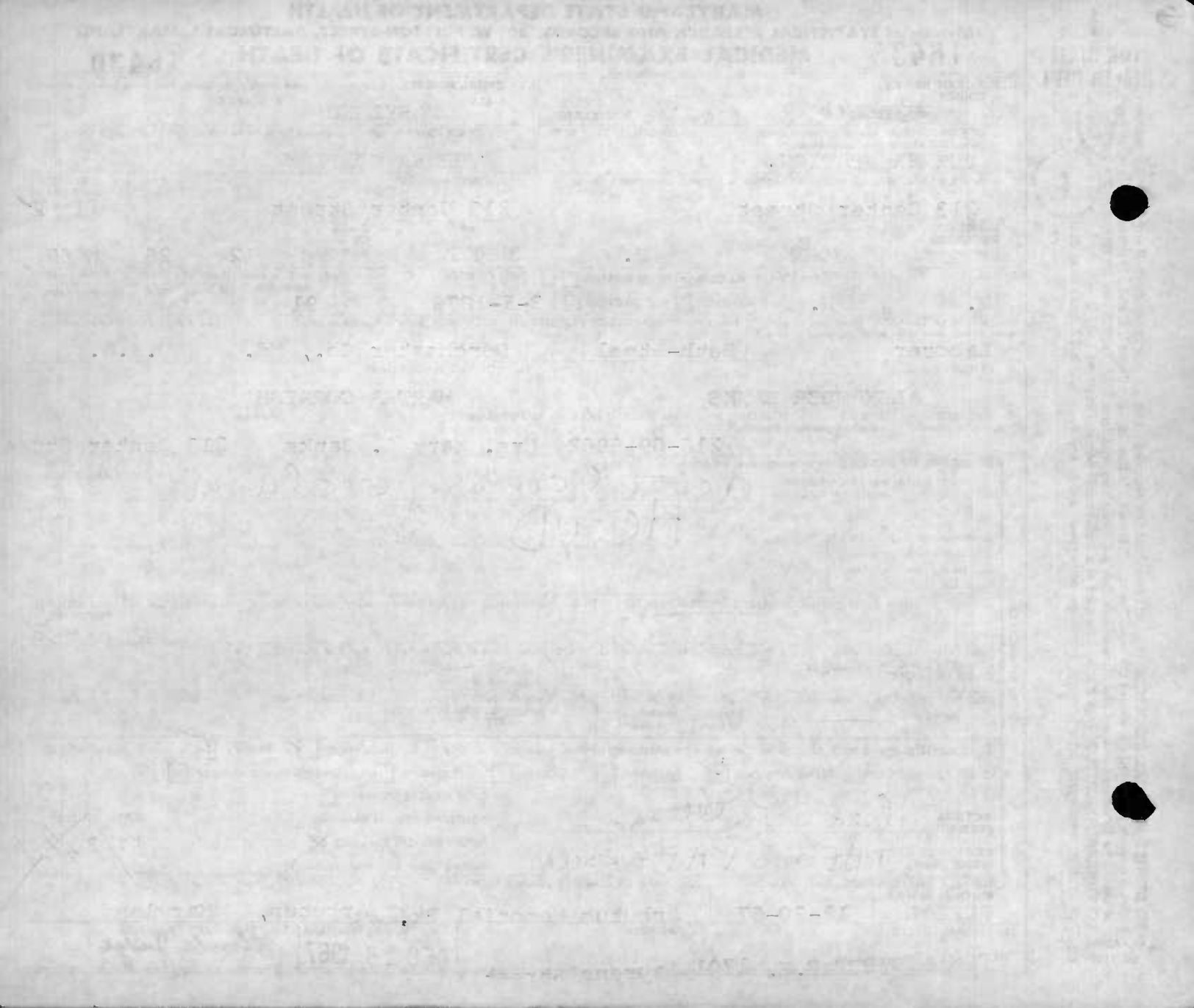
16438

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16430

1. PLACE OF DEATH e. COUNTY DUNDELL (Baltimore) MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY BALTO			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TURNER STATION				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TURNER STATION			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 213 Center Street				d. STREET ADDRESS 213 Center Street			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN B. BANKS				4. DATE OF DEATH Month Day Year 12 26 19 67			
5. SEX M.		6. COLOR OR RACE N.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-5-1876	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Beth-Steel		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ALEXANDER BANKS				14. MOTHER'S MAIDEN NAME MARTHA CORNISH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 216-09-6962			
17. INFORMANT Mrs. Mary L. Banks				Address 213 Center Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 acute coronary occlusion DUE TO HCVD (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Theo C Patterson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) THEO. C PATTERSON				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-30-67		22c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk.		22d. LOCATION (City, town, or country) (State) Arbutus, Maryland	
23. FUNERAL DIRECTOR MORTON & DYETT F.H. 1701 Laurens Street				24a. REC'D BY REGISTRAR DEC 28 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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16439

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16431

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			d. STREET ADDRESS 2308 Cider Mill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Joseph H. Bartholme			4. DATE OF DEATH Month Dec. Day 15 Year 19 67		
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1888		9. AGE (In years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (County & State, or foreign country) Germany	
13. FATHER'S NAME Joseph A Bartholme			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-34-5478-A		17. INFORMANT Mrs Hattie J Bartholme Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Cardio Pulmonary Failure DUE TO (b) Arteriosclerotic C.V.D. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Nov. 5, 19 67 , to Dec. 15, 19 67 that (I) (we) lost saw the deceased alive on Dec. 15 19 67 , and that death occurred at 8:15 p.m. from causes and on the date stated above.					
22a. SIGNATURE Benjamin del Carmen		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED Dec. 15, 1967		
22c. PHYSICIAN'S NAME (Type) Dr. Benjamin delCarmen		22d. ADDRESS St. Joseph Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/19/67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR Leonard J Ruck Inc 5305 Harford Rd			25a. REC'D BY REGISTRAR DATE DEC 18 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge

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ESTIMATE OF BURN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16440

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16432

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Professional House, Inc.		e. STREET ADDRESS HIGHFIELD HOUSE, APT. 503 4000 N. Charles Street	
3. NAME OF DECEASED (Type or print) First Joseph		Last Beck	
4. DATE OF DEATH Month 12		Day 15	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/22/90	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 12	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Beck		14. MOTHER'S MAIDEN NAME Krieger, MOLIE LEAH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W.W. I	
17. INFORMANT MRS. BLANCHE BECK		Address 4000 N. CHARLES ST., APT 503 4000x HIGHFIELD HOUSE #18	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH days un Known	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 10-26 , 19 67 , to 12-15 , 19 67 , that (1) (we) last saw the deceased alive on 12-15 , 19 67 , and that death occurred at 11:00 M, from the causes and on the date stated above.			
22a. SIGNATURE David I. Miller		22b. DATE SIGNED 12-15-67	
22c. PHYSICIAN'S NAME (Type) David I. Miller		22d. ADDRESS Union Rd. - Owings Mills Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-17-67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		23d. LOCATION (City, town or county) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD		25a. REC'D BY REGISTRAR DEC 22 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

WILLIAM

Severe arteriosclerosis
Cerebral vascular accident

Samuel Beck

Krieger, W. L. W.

NAME - WHITE

0/22/90

Joseph

beck

10/20/97

4000 E. Charles Street

BATHING, MARYLAND

BATHING MARYLAND

12-17-97

SUNNY

201 BATHING & BOD. THE 1001 BATHING ROAD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
16441			
16433			
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY in lb 11 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium md. 21093		03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Balts. Medical Center		d. STREET ADDRESS 131 Hollow Brooke Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emma Anna Becker		4. DATE OF DEATH Month December Day 3 Year 1967	
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-09-84
9. AGE (In years lost birthday) 83 yrs.		IF UNDER 1 YEAR Months 3 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Hans Leivity		14. MOTHER'S MAIDEN NAME Grinath	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212-05-7361	
17. INFORMANT H. Chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 29 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mild Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/23 , 19 67 , to 12/3 , 19 67 , that (I) we last saw the deceased alive on 12/3 , 19 67 , and that death occurred at 2 P M, from causes and on the date stated above.			
22a. SIGNATURE Derek H Bruce		22b. DATE SIGNED 12/3/67	
22c. PHYSICIAN'S NAME (Type) DEREK H. BRUCE		22d. ADDRESS G. B. M. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-6-67	23c. NAME OF CEMETERY OR CREMATORY Baltimore	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Rd.		25a. REC'D BY REGISTRAR NFC 7 25b. REGISTRAR'S SIGNATURE 1967 O'Brien Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16442

CERTIFICATE OF DEATH

16434

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 21204		c. LENGTH OF STAY IN 1b 8 mons		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore, Maryland 21206	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney Towson Nursing Home, 111 West Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine Elizabeth Beilein		4. DATE OF DEATH Month December Day 22 Year 1967		5. SEX female	
6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 10, 1889	
9. AGE (In years lost birthday) 78 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME U. Thim	
14. MOTHER'S MAIDEN NAME Catherine Eva Thim		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-20-7168-D	
17. INFORMANT Dulaney Towson Nursing Home, 111 West Road		18. ADDRESS 21204		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRCULATORY COLLAPSE DUE TO CEREBRAL MEMORCHAE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4/22, 1967 to 12/22, 1967 , that (I) (we) last saw the deceased alive on 12/20, 1967 , and that death occurred at 10:10 A.M. from causes and on the date stated above.			
22a. SIGNATURE T. C. Siwinski		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 22, 1967	
22c. PHYSICIAN'S NAME (Type) T. C. Siwinski, M.D.		22d. ADDRESS 206 W. Penna. Ave., Towson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/26/67		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer	
23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		24. FUNERAL DIRECTOR Leonard J Ruck Inc. 5305 Harford Rd			
25a. REC'D BY REGISTRAR DEC 27 1967		25b. REGISTRAR'S SIGNATURE [Signature]			

1944

DEPARTMENT OF AGRICULTURE

1944



[The page contains several lines of extremely faint, illegible text, likely bleed-through from the reverse side of the document. The text is arranged in a structured format, possibly a list or a series of entries, but the specific content cannot be discerned.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX				03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 147 HALL NURSING HOME						d. STREET ADDRESS 7910 BRIDGE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD BERK						4. DATE OF DEATH Month DEC Day 31 Year 1967					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/28/86		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BALTO. MD.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE BERK						14. MOTHER'S MAIDEN NAME P					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNK				16. SOCIAL SECURITY NO. 219-16-7054		17. INFORMANT AGNES SHEELER				Address RTE 16 BOX 482-17	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD with Marked DUE TO (c) Chronic Emphysema Interval between onset and death 5 yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1 , 1964, to Dec 31 , 1967, that (I) (we) last saw the deceased alive on Dec 31 , 1967, and that death occurred at 11 M, from causes and on the date stated above.											
22a. SIGNATURE G.M. Baumgardner M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/3/68			
22c. PHYSICIAN'S NAME (Type) G.M. BAUMGARDNER						22d. ADDRESS BALTO 21237					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/4/68		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART				23d. LOCATION (City or Town) (County) (State) BALTO. MD.			
24. FUNERAL DIRECTOR J.G. CONNELLY SONS						ADDRESS 300 MACC		25a. REG'D BY REGISTRAR JAN 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
16444		CERTIFICATE OF DEATH	
16436			
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANMILLS TOWN</u>		c. LENGTH OF STAY IN 1b <u></u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		d. STREET ADDRESS <u>3604 Greenmount Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. County General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALBERT R BEVANS Sr.</u>		4. DATE OF DEATH Month <u>12</u> - Day <u>1</u> - Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-00</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Retired Sales</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTO. Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Bevans</u>		14. MOTHER'S MAIDEN NAME <u>Julia A. Bayne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>215-10-8115</u>	
17. INFORMANT <u>Eva Bevans</u>		Address <u>Same.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> DUE TO (b) <u>Pulmonary Embolism, Bronchopneumonia</u> DUE TO (c) <u>Pericarditis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>350 X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>12/1/67</u> , 19 <u>67</u> , to <u>12/1/67</u> , 19 <u>67</u> , that (I) (<u>we</u>) lost saw the deceased alive on <u>12/1/67</u> , 19 <u>67</u> , and that death occurred at <u>7:01 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Elliott Michelson</u>		22b. DATE SIGNED <u>12/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Elliott Michelson</u>		22d. ADDRESS <u>1801 Eutaw Place Balto 21217</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 5 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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Ballantine

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John H. Brown

John H. Brown

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
25M 1/67

MEDICAL CERTIFICATION

16445		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		16437	
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 30 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINISTER	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS RD #6	
3. NAME OF DECEASED (Type or print) First Middle Last AUGUSTUS WINFIELD BITZEL				4. DATE OF DEATH Month Day Year DECEMBER 9, 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/95	9. AGE (In years last birthday) yrs. 72	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY distillery		11. BIRTHPLACE (County & State, or foreign country) CARROLL COUNTY, MARYLAND	
13. FATHER'S NAME CHARLES H. BITZEL				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME ELIZABETH CROOKS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 213-12-6593		17. INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO-PNEUMONIA 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) ARTERIOSCLEROTIC CADRIOVASCULAR DISEASE					INTERVAL BETWEEN ONSET AND DEATH DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS, ARTERIOSCLEROTIC OBLITERANS LEGS					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOV 9, 19 67 , to DEC 9, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DEC 9, 19 67 , and that death occurred at 6:05A M, from causes and on the date stated above.					
22a. SIGNATURE Chong Choon Han M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/9/67	
22c. PHYSICIAN'S NAME (Type) CHONG CHOON HAN		22d. ADDRESS VAH, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/12/67	23c. NAME OF CEMETERY OR CREMATORY TRINITY LUTHERAN CEM.	23d. LOCATION (City or Town) (County) (State) FINKSBURG, MD. CARROLL Co.		
24. FUNERAL DIRECTOR MYERS FUNERAL HOME		ADDRESS WESTMINSTER, MD.		25a. REC'D BY REGISTRAR DATE DEC 12 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16446

16438

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS Box 394 Rt 16	
3. NAME OF DECEASED (Type or print) First ROY Middle WREATH Last BLANTON		4. DATE OF DEATH Month Dec. Day 27 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/92
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Co.	
11. BIRTHPLACE (County & State, or foreign country) Cherokee, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew P. Blanton		14. MOTHER'S MAIDEN NAME Mossie E. Vinesett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 240 07 98 40	
17. INFORMANT Clinical Rcds, VA Hospital, Fort Howard Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHOPNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 10 , 19 67 , to Dec. 27 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 27 , 19 67 , and that death occurred at 1:15 PM , from causes and on the date stated above.			
22a. SIGNATURE John D. Talbert		22b. DATE SIGNED 12/27/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		22d. ADDRESS VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/67	
23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Connelly Funeral Home		25a. REC'D BY REGISTRAR Essex, Md.	
25b. REGISTRAR'S SIGNATURE James Judge		DATE JAN 2 1968	

16447

CERTIFICATE OF DEATH

16439

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN lb 45 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS 842 Konig Street	
3. NAME OF DECEASED (Type or print) First Anna Middle - Last BOBROFSKY		4. DATE OF DEATH Month 12 Day 20 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-10
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Israel Bobrofsky		14. MOTHER'S MAIDEN NAME Lena Friedman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO Arterial Sclerotic Coronary Vascular Disease with Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Sclerotic Coronary Vascular DUE TO Disease with Thrombosis (c)		INTERVAL BETWEEN ONSET AND DEATH terminal years terminal	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from 1/16 , 19 66 , to 12/20 , 19 67 , that (if we) last saw the deceased alive on 12/20 19 67 , and that death occurred at 8:05 Ma causes and on the date stated above.			
22a. SIGNATURE Richard A. Jones		22b. DATE SIGNED 12/20/67	
22c. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.		22d. ADDRESS Rosewood St. Hosp., Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/22/1967	
23c. NAME OF CEMETERY OR CREMATORY Rosewood Hospital Cemetery		23d. LOCATION (City or Town) (County) (State) Owings Mills, Md	
24. FUNERAL DIRECTOR Sylvan Lewis & Son		25a. REC'D BY REGISTRAR GARRISON MD	
25b. REGISTRAR'S SIGNATURE Charles Jones		DATE DEC 26 1967	

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Page 4 may be retained by the hospital or attending physician.

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1843

STATEMENT OF DEATH

1843

Acute Myocardial Infarction
Atrial Septal Defect
Diagnosed with Thompson's

Richard A. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
ZDM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
16448 CERTIFICATE OF DEATH 16440													
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GREATER BALTIMORE</u> c. LENGTH OF STAY IN 1b <u>2 1/2</u> yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md</u> d. STREET ADDRESS <u>6701 North Charles</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>DOROTHY</u> Last <u>Bohenberg</u>			4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1968</u>			5. SEX <u>FEMALE</u>			6. COLOR OR RACE <u>W</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>12-5-1918</u>			9. AGE (In years last birthday) <u>50</u> yrs.			IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE Md.</u>			12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <u>John Popp</u>						14. MOTHER'S MAIDEN NAME <u>Smith</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>215-10-3398</u>			17. INFORMANT <u>Admission Sheet</u>			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory collapse due to</u> <u>1750</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive metastases fr.</u> (c) <u>Carcinoma of the ovary</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>11-17, 1967</u> to <u>12-5, 1967</u> , that (I) (we) last saw the deceased alive on <u>12-5 - 1967</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.													
22a. SIGNATURE <u>J. J. J.</u>						22b. DATE SIGNED <u>12-5-67</u>			22c. PHYSICIAN'S NAME (Type)				
22d. ADDRESS <u>GBMC</u>						22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22f. ATTENDING PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>12/9/67</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Lawson's Faith</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore</u>				
24. FUNERAL DIRECTOR <u>Philip H. H. H.</u>						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

0330

287

RENTAL RECORDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 33 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS 7151 Eastbrook Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH WALTER BOLGER					4. DATE OF DEATH Month DECEMBER Day 16 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/16/18		9. AGE (In years lost birthday) yrs. 49	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cutter			10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Bolger					14. MOTHER'S MAIDEN NAME Eva Kieltyka				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WWII			16. SOCIAL SECURITY NO. 216-07-0868		17. INFORMANT Clin. Rec. VA Hospital, Fort Howard, Maryland Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LARYNX 161X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) METASTATIC CARCINOMA BOTH SIDES OF NECK DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH YEARS MONTHS									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour "a.m." 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from November 13 19 67 , to December 16 67 , that X (we) last saw the deceased alive on December 16 19 67 , and that death occurred at 9:25 AM , from causes and on the date stated above.									
22a. SIGNATURE Rodolfo G. Miro, M.D.					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 12/16/67	
22c. PHYSICIAN'S NAME (Type) RODOLFO G. MIRO, M.D.					22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/20/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR John M. Weber & Sons Inc.					401 S. Chester St. Baltimore, Maryland		25a. REC'D BY REGISTRAR DEC 18 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

16450

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16442

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7520 YORK H ROAD ST. JOSEPH HOSP.		d. STREET ADDRESS 7011 ARION AVE	
3. NAME OF DECEASED (Type or print) HOWARD R. BOWEN		4. DATE OF DEATH Month 12 Day 8 Year 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-05
9. AGE (In years lost birthday) yrs. 62		10. IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min. 19	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECT. MAINTENANCE		12. KIND OF BUSINESS OR INDUSTRY MARTIN CO.	
13. BIRTHPLACE (State or foreign country) MARYLAND		14. CITIZEN OF WHAT COUNTRY USA	
15. FATHER'S NAME HOWARD BOWEN		16. MOTHER'S MAIDEN NAME JEANIE ROSS	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		18. SOCIAL SECURITY NO. 218013301	
19. INFORMANT BESSIE BOWEN, 7011 ARION AVE. 21234		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary Occlusion Sudden DUE TO (b) Emphysema DUE TO (c) 241st			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		22. DATE SIGNED 12/8/67	
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12-11-67	23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.
24. FUNERAL DIRECTOR HOWARD H. HUBBARD 4107 WILKENS AVE., 21229		25a. REC'D BY REGISTRAR DEC 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16451

16443

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 21207 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3910 Milford Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hilda M. Brady		4. DATE OF DEATH Month Dec. Day 27 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/1891
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eli Free Matthews		14. MOTHER'S MAIDEN NAME Barbara Ellen Sparwasser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 442-01-1620B	
17. INFORMANT Roland H. Brady, Jr.		18. ADDRESS 305 Princeton Blvd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho. pneumonia DUE TO (b) Arterio-sclerotic Heart Disease DUE TO (c) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 5 days 2 yrs 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio-sclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 29, 1959 , to Dec. 27, 1967 , that (I) (we) last saw the deceased alive on Dec. 27, 1967 , and that death occurred at 10:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE Earl L. Chambers		22b. DATE SIGNED 12/29/67	
22c. PHYSICIAN'S NAME (Type) Dr. Earl Chambers		22d. ADDRESS 4108 Liberty Hghts. Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/67	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Pikesville, Balto. Co. Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR JAN 2 1968	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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16452

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16444

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Arbutus	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		d. STREET ADDRESS 4502 Leeds Ave., 21229	
3. NAME OF DECEASED (Type or print) HENRIETTA H. BRAUN		4. DATE OF DEATH Month Dec Day 21 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/23/91
9. AGE (In years lost birthday) yrs. 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cart Trebess		14. MOTHER'S MAIDEN NAME Emma V. Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-3182	
17. INFORMANT Mr. Walter H. Braun, Jr., 1111 Dorchester Ave.		Address 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1810 IMMEDIATE CAUSE (a) Transitional Carcinoma bladder DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1966 to Dec 21, 1967 , that (I) (we) last saw the deceased alive on 12-19-1967 , and that death occurred 4:57 P.M. from causes on and on the date stated above.			
22a. SIGNATURE Earl I. Pass		22b. DATE SIGNED 12-21-67	
22c. PHYSICIAN'S NAME (Type) Earl I. Pass		22d. ADDRESS 4001 Wilkens Ave., Baltimore, Md. 21229	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/67	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. RECEIVED BY REGISTRAR DEC 26 1967	
25b. REGISTRAR'S SIGNATURE James J. Jones		26. REGISTRAR'S SIGNATURE	

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THE UNIVERSITY OF CHICAGO

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN TB <u>1MTH 8DYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg (20710)</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>					d. STREET ADDRESS <u>4202 53rd Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Milton Brickerd</u>					4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>19 67</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>10/24/30</u>		9. AGE (In years last birthday) yrs. <u>36</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber, unemployed</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Brickerd</u>					14. MOTHER'S MAIDEN NAME <u>Ethel M. Harvey</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>578 40 6466</u>		17. INFORMANT Address <u>Records: Spring Grove State Hospital</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>1939</u> IMMEDIATE CAUSE (a) <u>ASTROCYTOMA, Grade 3 or 4.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>7 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <u>1</u> (this hospital) attended the deceased from <u>10/30</u> , 19 <u>67</u> to <u>12-8</u> , 19 <u>67</u> , that <u>1</u> (we) last saw the deceased alive on <u>12-8</u> , 19 <u>67</u> , and that death occurred at <u>3:45</u> M., from causes and on the date stated above.									
22a. SIGNATURE <u>Anthony J. Young, M.D.</u>					22b. DATE SIGNED <u>12-8-67</u>			22c. PHYSICIAN'S NAME (Type) <u>Anthony J. Young, M.D.</u>	
22d. ADDRESS <u>Spring Grove State Hospital</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 11, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>		
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>DEC 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 15
20 M 1/66

16454 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items 5 & 6 Film G390 12/20/67 KK											
CERTIFICATE OF DEATH											
16446											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Balto.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE MD.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT CONV. HOME</u>						d. STREET ADDRESS <u>5717 EDMONDSON AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>H</u> Last <u>BROWN</u>						4. DATE OF DEATH Month <u>DEC</u> Day <u>7</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-27-1881</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACK SMITH</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE BROWN</u>						14. MOTHER'S MAIDEN NAME <u>ELIZABETH SHELBY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC SIGNIFICANT CORONARY</u> DUE TO <u>RESULTING AORTIC</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>ARTERIO-SCLEROTIC CHANGES - VASCULAR</u> DUE TO (c) <u>DISEASE</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>62</u> , to <u>12/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/7</u> 19 <u>67</u> , and that death occurred at <u>7:30 PM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>John M. Sauer MD.</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/7/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>John M. Sauer MD.</u>						22d. ADDRESS <u>5717 EDMONDSON AVE. CATONSVILLE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/9/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PAR</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO MD.</u>					
24. FUNERAL DIRECTOR <u>WEVER FUNERAL HOME</u>						ADDRESS <u>5311 EDMONDSON AVE</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL	
c. LENGTH OF STAY IN 1b 2 mos. 8 days		d. STREET ADDRESS 809 WEST STREET.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES ALFRED BROWN		4. DATE OF DEATH Month 12 Day 26 Year 1967	
5. SEX M.	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4, 24, 1913
9. AGE (In years lost birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR	
11. BIRTHPLACE (County & State, or foreign country) SILVER SPRING, MD.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME ULYSSES BROWN		14. MOTHER'S MAIDEN NAME SARAH WARNER.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-28-9876	
17. INFORMANT Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO (b) Pneumonitis, terminal, staphylococcal DUE TO (c) Ca of the lung, Lt, squamous cell.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Tuberculosis.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10, 18, 1967 to 12, 26, 1967 , that (I) (we) last saw the deceased alive on 12, 26, 1967 , and that death occurred at 6:00 PM , from causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type or print) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/2/68	23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery	23d. LOCATION (City or Town) (County) (State) Bacontown, Md.
24. FUNERAL DIRECTOR George R. Snowden		25a. REC'D BY REGISTRAR JAN 2 1968	
25b. REGISTRAR'S SIGNATURE James J. Judge			

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OFFICE OF THE

Baltimore

Mount Wilson

Mount Wilson State Hospital

Records, Mt. Wilson State Hospital

Mr. [Name], M.D., Superintendent, Mount Wilson, Maryland

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16456		16448	
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b 1 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reisterstown Road at Valley Rd		d. STREET ADDRESS 1417 Jeffers, Rd.	
3. NAME OF DECEASED (Type or print) David First Donald Bryson		4. DATE OF DEATH Dec. 23 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29th. 1925
9. AGE (In years (b. day) yrs. 42)		10. IF UNDER 1 YEAR Months 1 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director		10b. KIND OF BUSINESS OR INDUSTRY Funeral	
11. BIRTHPLACE (State or foreign country) Rock Springs Wyoming.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Emery Bryson		14. MOTHER'S MAIDEN NAME Bonnie Hampton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW.I		16. SOCIAL SECURITY NO. 522-24-2063	
17. INFORMANT Sally Bryson (Wife)		Address 1417 Jeffers, Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head (suicide) DUE TO (b) 976X DUE TO (c) Interval between onset and death 1 hr. (est.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased shot self in head w 22 revolver	
20c. TIME OF INJURY Month, Day, Year 4 p.m. (AG) Dec 23 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sylvan Lewis Funeral Home Garrison Balt Md	20f. (City or town) (County) (State) Garrison Baltimore Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples M.D.		22. DATE SIGNED 12-24-67	
EXAMINER'S NAME (Type) D. D. CAPLES		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 26th. 1967	23c. NAME OF CEMETERY OR CREMATORY East View Cemetery	23d. LOCATION (City or Town) (County) (State) Newton, North Carolina.
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son		25a. REC'D BY REGISTRAR Charles Judge	
Address Memorial Chapel		25b. REGISTRAR'S SIGNATURE Charles Judge	
P.O. Box 65 Garrison Md		DATE DEC 27 1967	

1945

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UNITED STATES DEPARTMENT OF AGRICULTURE

Washington

London

1945

1944

Dec. 11

July 20, 1944

and for the purpose of

being used

for the purpose of (1) to (17) letters

United States (Circular)

Record of all in July 22, 1945

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D. D. CATES

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United States Department of Agriculture

Washington, D. C.

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United States Department of Agriculture

Washington, D. C.

1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
16457			
CERTIFICATE OF DEATH			
16449			
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
c. LENGTH OF STAY IN 1b 18 DAYS		d. STREET ADDRESS 35C BYWAY SOUTH	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALVIN Middle OSCAR Last BUCKNER		4. DATE OF DEATH Month DECEMBER Day 29 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/10/95
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 29 Days 19 Hours 67 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		11b. KIND OF BUSINESS OR INDUSTRY TEXTILE	
12. BIRTHPLACE (County & State, or foreign country) MARSHALL, N. CAROLINE		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM		14. MOTHER'S MAIDEN NAME LAURA RECLOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WWI		16. SOCIAL SECURITY NO. 251 30 56 17	
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE DUE TO (c) UNK.		INTERVAL BETWEEN DEATH AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC ADHESIVE PLEURITIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DEC 11 , 19 67 , to DEC 29 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DEC 29 , 19 67 , and that death occurred at 11:30PM , from causes and on the date stated above.			
22a. SIGNATURE John D. Talbert M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/2/68	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE THEREOF 1/5/68	23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR FISHER FUNERAL HOME		25a. REC'D BY REGISTRAR JAN 5 1968	
ADDRESS 1930 EASTERN AVE. BALTIMORE, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	

OTHER POWERED NAME

BALTIMORE, MD.
1030 EASTERN AVE.

1955

BURIAL

BALTO. NATIONAL CEMETERY

BALTIMORE, MARYLAND

JOHN L. GATHER, JR.

AND EVELYN GATHER, WIFE

X

DEC 29 01

DEC 11 11:30P

DEC 29 01

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YES 30 25 14 CLINICAL RECORDS, VAN, W. L. HOWARD, MD.

WILLIAM

LEWIS KECOR

LABORER

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MARSHALL, N. CAROLINA

U.S.A.

MALE

WHITE

X

OSCAR

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10/10/52

75

VETERANS ADMINISTRATION HOSPITAL

350 HWY 300TH

18 DAYS

REY HOWARD

WASHINGTON

BALTIMORE

MARYLAND

1955

DEPARTMENT OF AGRICULTURE

1955

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16458

16450

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> c. LENGTH OF STAY in 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Balto. Co. General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4824 Palmer Ave</u> 30.4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel P. Buell</u>				4. DATE OF DEATH Month Day Year <u>Dec. 17, 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-10-87</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Milk Company</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Buell</u>				14. MOTHER'S MAIDEN NAME <u>Martha Wisner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-10-2611</u>		17. INFORMANT Address <u>Mrs. Nellie Brewer</u> (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> (b) <u>Arteriosclerosis</u> (c) <u>Acute Pulmonary Embolism 20th pos. Pulm. Embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> to <u>12/17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/17</u> , 19 <u>67</u> , and that death occurred at <u>9:26pm</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Acting</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>12/17/67</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>Balto. County General Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> ADDRESS				25a. REC'D BY REGISTRAR <u>DEC 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY TOWSON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 2922 HUDSON STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last ANDREW LEONARD BUETTNER			4. DATE OF DEATH Month Day Year DEC. 16 1967			5. SEX MALE			6. COLOR OR RACE CAU		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12/23/06			9. AGE (In years last birthday) 60 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER			10b. KIND OF BUSINESS OR INDUSTRY BAKERY			11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN BUETTNER						14. MOTHER'S MAIDEN NAME K. DUEMMERICK					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. 212-22-3678			17. INFIRMANT CHART ADMISSION SHEET.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Esophagus DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 11/30/67 12/16/67											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 11/30/67 , to 12/16/67 , that (I) (we) last saw the deceased alive on 12/16/67 , and that death occurred at 10:30 AM , from the causes and on the date stated above.											
22a. SIGNATURE A. Pirnia, M.D.						22b. DATE SIGNED 12/16/67					
22c. PHYSICIAN'S NAME (Type) DR. PIRNIA M.D.						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12-19-67			23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery			23d. LOCATION (City, town or county) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Nicholas T. Mattheis			25a. REC'D BY REGISTRAR 3021 Eastern Ave.			25b. REGISTRAR'S SIGNATURE Charles J. Jones			DATE DEC 21 1967		

CHIEF CLERK

22-10-1914

Chief of Police
Premier

to Prime Minister

12/10/14
12/10/14
12/10/14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore - County</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto. Medical Center</u>						d. STREET ADDRESS <u>1600 East Coldspring Lane</u>					
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Mae</u> Last <u>Burdette</u>						4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-16-05</u>		9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Akron, Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Westfall</u>						14. MOTHER'S MAIDEN NAME <u>Rachel (Westfall) unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Hypopharynx</u> 147X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-12-67</u> , 19 <u> </u> to <u>12-12-67</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>12-12-67</u> , 19 <u> </u> , and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>P B Briscoe Jr</u>										22b. DATE SIGNED <u>12-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>P B BRISCOE Jr.</u>						22d. ADDRESS <u>Greater Balto. Med. Center</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>				23b. DATE THEREOF <u>12-16-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE MD</u>			
24. FUNERAL DIRECTOR <u>ROBERT C. ALTENBURG</u> <u>FUNERAL HOME, INC</u>						25a. REC'D BY REGISTRAR <u>6009 HARFORD RD</u>		25b. REGISTRAR'S SIGNATURE <u>DEC 20 1967</u> <u>Charles Judge</u>			

Exhibit 12-10-17 Green Mount
Robert A. Bingham
10000 10000

Baltimore

CERTIFICATE OF DEATH

16453

Item #13 Film #G3961/2/68ph
16453 Item #9 Film #G 396 12/20/4 ph

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY IN TB month d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. 3 Box 48 Hanover Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville d. STREET ADDRESS 4 Shawan Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles C. Burke		4. DATE OF DEATH Month December Day 8 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1889
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 03 Days 07	11. IF UNDER 24 HRS. Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Conrad A. Burk		14. MOTHER'S MAIDEN NAME Mary E. Guyton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 216-07-4349	
17. INFORMANT Mrs. Mary B. Turnbaugh		Address Rt. 3 Box 48 Hanover Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma - right lung Conditions, if any, which gave rise to immediate cause (b) 1621 (a), stating the underlying cause last. (c) 5 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 00 e.m. 00 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1967 , that (I) (we) last saw the deceased alive on December 8, 1967 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Clarence E. McWilliams		22b. DATE SIGNED 12-8-67	
22c. PHYSICIAN'S NAME (Type) 11904 Reisterstown Rd Reisterstown Md 21136		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/11/67	23c. NAME OF CEMETERY OR CREMATORY St. Johns Lutheran Cemetery	23d. LOCATION (City, town or county) (State) Sweet Air, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Brooks		25a. REC'D BY REGISTRAR (Type) REGISTRAR'S SIGNATURE DEC 13 1967	
Towson 1050 York Rd. 21204		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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16462

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16454

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7112 York Road</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> d. STREET ADDRESS <u>7112 York Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HOWARD E. BURKHARDT</u>		4. DATE OF DEATH <u>DEC. 1 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-95</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret., Balto. Cty. Supt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>of Assessments</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Balto., Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John G. Burkhardt</u>	
14. MOTHER'S MAIDEN NAME <u>Laura Bradburn</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give year or dates of service) <u>W.W.I</u>	
16. SOCIAL SECURITY NO. <u>215-05-2251</u>		17. INFORMANT <u>Mary A. Burkhardt</u> Address <u>7112 York Road Balto., Md 21212</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> (c) <u>6 YRS.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 15 1967</u> , to <u>12-1-67</u> , that (I) (we) last saw the deceased alive on <u>Nov. 15 1967</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William A. Pillsbury</u> M.D.		22b. DATE SIGNED <u>12-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>		22d. ADDRESS <u>Timonium, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>12/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	23d. LOCATION (City, town or county) (State) <u>Balto. County, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mitchell-Wiedefeld</u> ADDRESS <u>Home 6500 York Road Balto., Md. 21212</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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DEC 7 1955

RECEIVED - FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balt									
b. CITY OR TDWN (if outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville			d. STREET ADDRESS 1207 Black Friars Rd. 21228						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1207 Black Friars Rd 21228					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Ida Middle Velinda Last Butz			4. DATE OF DEATH Month 12 Day 3 Year 1967											
5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/2/81		9. AGE (In years last birthday) 86 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Jesse N. Hill					14. MOTHER'S MAIDEN NAME Elizabeth Hart									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 218-07-6758D		17. INFORMANT Mrs Vera Moore Address 44 Dunkirk Rd. Balt. Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 MYocardial INFARCTION DUE TO (b) M.O. V.D. - Myocardial Ischemia DUE TO (c) Myocardial INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 9/1 , 19 67 , to 12/3 , 19 67 , that (I) (we) last saw the deceased alive on 12/3 , 19 67 , and that death occurred at 9 PM , from the causes and on the date stated above.														
22a. SIGNATURE John H. Shapiro					22b. DATE SIGNED 12/4/67		22c. PHYSICIAN'S NAME (Type) John H. Shapiro							
22d. ADDRESS 5501 Edmonson Ave. Baltimore, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/6/67		23c. NAME OF CEMETERY OR CREMATORY Louisa Park			23d. LOCATION (City, town or county) (State) Baltimore, Md.						
24. FUNERAL DIRECTOR Wm. Cook-Brooks West, Inc ADDRESS Balt. Md. 21228					25a. REC'D BY REGISTRAR DEC 7 1967					25b. REGISTRAR'S SIGNATURE J. Charles Jones				

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darwin</u>		c. LENGTH OF STAY IN 1b <u>Pikeville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forkleigh Nursing Home</u>		d. STREET ADDRESS <u>8203 Pumpkin Seed Ct</u>	
3. NAME OF DECEASED (Type or print) First <u>Maurice</u> Middle <u>U.</u> Last <u>Cohn</u>		4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 9, 1871</u>
9. AGE (In years last birthday) <u>96</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard Cohn</u>		14. MOTHER'S MAIDEN NAME <u>Hannah?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Seed Ct</u>	
17. INFORMANT <u>Charles Cohn Jr - 8203 Pumpkin</u>		Address <u>Seed Ct</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobular</u> DUE TO (b) <u>5 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Benign Prostatic Hypertrophy</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter notes of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>Dec 8, 1967</u> , that (I) (we) lost saw the deceased alive on <u>Dec 8</u> 19 <u>67</u> , and that death occurred at <u>6:30 AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Alan Bernstein</u>		22b. DATE SIGNED <u>12/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALAN BERNSTEIN</u>		22d. ADDRESS <u>819 Park Ave Balt 21201</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec 10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Balto Hebrew</u>	23d. LOCATION (City or town) (County) (State) <u>Balto. Md</u>
24. FUNERAL DIRECTOR <u>Sol Leiman & Pincus</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 12 1967</u>	

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1. Name of deceased
2. Age
3. Sex
4. Color
5. Occupation
6. Cause of death
7. Date of death
8. Place of death
9. Name of physician
10. Name of undertaker
11. Name of funeral home
12. Name of cemetery
13. Name of burial place
14. Name of interment place
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16465						CERTIFICATE OF DEATH			16457		
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b 17 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington				17-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital						d. STREET ADDRESS R.F.D.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Evelyn First - Middle CANNON Last						4. DATE OF DEATH 12 Month 20 Day 1967 Year					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-19-45		9. AGE (In years last birthday) 22 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Baltimore City, M.D.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Cannon						14. MOTHER'S MAIDEN NAME Dorothy Hamilton					
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Rosewood Records, Owings Mills, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia/deficiency Asphyxia DUE TO 3255 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Aspiration of food/ Aspiration of gastric contents DUE TO (c) Mental Retardation/										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Institutionalization, 17 years, Mental Retardation Severe										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from 2/21 , 19 50 , to 12/20 , 19 67 , that (1) (we) last saw the deceased alive on 12/20 , 19 67 , and that death occurred at 10:10 a.m. causes and on the date stated above.											
22a. SIGNATURE Richard A. Jones M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/21/67			
22c. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.						22d. ADDRESS Rosewood St. Hosp., Owings Mills, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-24-67		23c. NAME OF CEMETERY OR CREMATORY Greensboro				23d. LOCATION (City or Town) (County) (State) Greensboro, Md.			
24. FUNERAL DIRECTOR John E. Boulton, Greensboro, Md.						25a. REC'D BY REGISTRAR DEC 27 1967		25b. REGISTRAR'S SIGNATURE James Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 14
25M 1767

16466		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		16458	
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT HOWARD		c. LENGTH OF STAY IN lb 113 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3145 CLIFTMONT AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last JOE (or JOSEPH) CARLO				4. DATE OF DEATH Month Day Year DECEMBER 19 1967	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7 27 92		9. AGE (In years lost birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BROOM MAKER		12. KIND OF BUSINESS OR INDUSTRY Md. Blind Shop		13. BIRTHPLACE (County & State, or foreign country) Italy	
14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. FATHER'S NAME CARMELLO CARLO		16. MOTHER'S MAIDEN NAME ROSARIA VICARI	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		18. SOCIAL SECURITY NO. 212 32 3307		19. INFORMANT CLINICAL RECORDS VA HOSP FT HOWARD, MD	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334x PNEUMONIA, BILATERAL, ASPIRATION, UNDETERMINED ORGANISM-DAYS DUE TO (b) — DUE TO (c) CHRONIC BRAIN SYNDROME, CEREBRAL ARTERIOSCLEROSIS UNKNOWN		21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		22. INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
24a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		24b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		24c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
24d. (City or town)		24e. (County)		24f. (State)	
25. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/28/67 , 19__, to 12/19/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/19/67 , 19__, and that death occurred on 8:00A , from causes on and on the date stated above.					
26a. SIGNATURE Neilon Neilson		26b. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		26c. DATE SIGNED 12/19/67	
26d. PHYSICIAN'S NAME (Type) NEILON NEILSON, M. D.		26e. ADDRESS VA HOSPITAL PORT HOWARD, MARYLAND			
27a. BURIAL, CREMATION, REMOVAL (Specify) Burial		27b. DATE THEREOF 12/22/67		27c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.	
27d. LOCATION (City or Town) Baltimore, Md.		27e. (County)		27f. (State)	
28. FUNERAL DIRECTOR SCHIMUNEKS FUNERAL HOME, BREHMS LANE BALTO MD		28a. ADDRESS		28b. REC'D BY REGISTRAR DEC 21 1967	
28c. REGISTRAR'S SIGNATURE [Signature]		28d. REGISTRAR'S SIGNATURE [Signature]			

VA HOSPITAL FORT HOWARD, MARYLAND

X 12/19/67

3:00A

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12/19/67

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VETERANS ADMINISTRATION HOSPITAL

MARYLAND

1968

STATEMENT OF DEATH

1968

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16467

16459

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 30.4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Briarcliff Apartments		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHESTER LLOYD CARROLL		4. DATE OF DEATH Month December Day 19 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	9. AGE (In years last birthday) 41 yrs. IF UNDER 1 YEAR Months Days Hours IF UNDER 24 HRS Min.
11. BIRTHPLACE (State or foreign country) Staunton, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cecil L. Carroll		14. MOTHER'S MAIDEN NAME Julia Holsinger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 1718 G. L. Carroll	
17. INFORMANT 1718 W. Lombard St.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 12/19/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Alleghany Mem. Pk. Cem.	23d. LOCATION (City or Town) (County) (State) Alleghany, Va.
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE DEC 21 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Werner U. Spitz	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16468

CERTIFICATE OF DEATH

16460

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY City, Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 54yr11mth23dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Carroll Last Carroll		4. DATE OF DEATH Month Dec. Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1899
9. AGE (In years last birthday) yrs. 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry K. Carroll		14. MOTHER'S MAIDEN NAME Mary Sullivan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bronchial, organism undeter- DUE TO provisional diagnosis. (b) Carcinoma of the lung, type undetermined, DUE TO 6 months (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchial(rt.)-esophageal fistula.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 28, 1967 to Dec. 23, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 23, 1967 , and that death occurred at 8:25M , from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED 12-23-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/27/1967	23c. NAME OF CEMETERY OR CREMATORY Mount Carmel Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR John A. Moran Inc. 3000 E. Baltimore Street		25a. REC'D BY REGISTRAR DEC 29 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16469

16461

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 45yr11mth16dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS unknown	
3. NAME OF DECEASED (Type or print) First Ira Middle C. Last Carson		4. DATE OF DEATH Month December Day 18 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1884
9. AGE (In years lost birthday) 83 yrs.		IF UNDER 1 YEAR Months 01 Days 12 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Illinois	
11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Carson		14. MOTHER'S MAIDEN NAME Jennie Herring	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 219-54-3064	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4201 Myocardial Infarction with supraventricular tachycardia IMMEDIATE CAUSE (a) lar tachycardia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic Cardiovascular Ht. Dis. DUE TO (c) 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Descent Suprapubic Cystolithotomy & Prostatectomy, 12/15/67, convalescent			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 2, 1922 , to Dec. 18, 1967 , that (I) we saw the deceased alive on Dec. 18, 1967 , and that death occurred at 4:30 P. M, from causes and on the date stated above			
22a. SIGNATURE Anthony J. Young, M.D.		22b. DATE SIGNED 12-18-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12-20-67	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Old Frederick Road Baltimore	
24. FUNERAL DIRECTOR Krause Funeral Home 1216 Schaefer St		25a. REC'D BY REGISTRAR DATE DEC 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECORDS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
16470		16463	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 83 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1200 N. Rolling Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			
3. NAME OF DECEASED (Type or print) ELMER First Middle Last CHANEY		4. DATE OF DEATH December 27 1967 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/94 9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Clarence Chaney		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW-1		14. MOTHER'S MAIDEN NAME Irene Williams	
16. SOCIAL SECURITY NO. 216 09 25 14		17. INFORMANT Clinical Rcds, VA Hospital, Ft Howard, Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO-PNEUMONIA DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE DUE TO HEART FAILURE (c)		INTERVAL BETWEEN ONSET AND DEATH Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS (CLINICAL) SURGICAL ABSENCE LEFT LEG		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 5 , 19 67 , to Dec. 27 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/27/67 19 67 , and that death occurred at 8:20 M, from causes and on the date stated above.			
22a. SIGNATURE MADHAV D. BARHANPURKAR		A. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.	
22c. PHYSICIAN'S NAME (Type) MADHAV D. BARHANPURKAR, M.D.		22b. DATE SIGNED 12/27/67	
22d. ADDRESS VA Hospital, Fort Howard, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 2, 1968	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Henry Sander & Sons Inc. SANDERS FUNERAL HOME		25a. REC'D BY REGISTRAR DATE JAN 2 1968 25b. REGISTRAR'S SIGNATURE Charles Judge	

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DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH

16464

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bush Land Road</u>		d. STREET ADDRESS <u>Bush Land Road</u>	
3. NAME OF DECEASED (Type or print) <u>Soph</u> First <u>Clarence</u> Middle <u>Chilcoat</u> Last		4. DATE OF DEATH Month <u>Dec.</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21 1879</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore County Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George R. Chilcoat</u>		14. MOTHER'S MAIDEN NAME <u>Laura Guyton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-54-1437</u>	
17. INFORMANT <u>Mrs Gladys Marshall</u>		Address <u>Parkton Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4221</u> IMMEDIATE CAUSE (a) <u>Arterio sclerosis Cardiac Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 6</u> , 19 <u>55</u> , to <u>Dec 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 10</u> 19 <u>67</u> , and that death occurred at <u>3:34 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush MD</u>		22b. DATE SIGNED <u>12-17-67</u>	
22c. PHYSICIAN NAME (Type) <u>Joseph E. Bush MD</u>		22d. ADDRESS <u>NAMPSTEAD Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/20/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Parkton, Balto., Md.</u>	
24. FUNERAL DIRECTOR <u>J. Jacob Hartenstein, New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>DEC 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF JUSTICE

100-100000

100-100000

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>30-4</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b <u>Almost 4 Month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto Medical Center</u>					d. STREET ADDRESS <u>2922 Elliott Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>STANISLAUS CICHOWICZ</u>					4. DATE OF DEATH Month Day Year <u>Dec. 21 19 67</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>CAY</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/31/1906</u>		9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Utility Man. Chevrolet</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Co.</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Cichowicz</u>					14. MOTHER'S MAIDEN NAME <u>Catherine Puwalski</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>					16. SOCIAL SECURITY NO. <u>Navy 1925-1928 213-10-4808</u>		17. INFORMANT (Wife) <u>Mrs. Jeannette Cichowicz, 2922 Elliott St.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Brain</u> <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of left lung</u> (c) <u>163X</u>								INTERVAL BETWEEN ONSET AND DEATH <u>About 4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT 1</u> , 1967, to <u>DEC 21</u> , 1967, that (I) (we) last saw the deceased alive on <u>DEC 21</u> , 1967, and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Manuel A. Gorgon</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Dec. 21, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>DR. STUART SUNDAY</u>					22d. ADDRESS <u>201 E. 33d 6701 N. CHARLES</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR <u>John J. Duda, 2829 Hudson St. Balto. Md.</u>					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

1855

1855

California

Alameda County

Township

1855

1855

United States

1855

1855

1855

California
Alameda County

Alameda
County

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1855

Alameda
County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 of this certificate should be retained by the funeral director and in any event within 72 hours after death.

1. NAME OF DECEASED (Type or Print)		MARGARET S. CLARK		2. DATE AND HOUR OF DEATH December 19, 1967. 8 P.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		BALTIMORE COUNTY 4417 Glenmore Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21206 D. STREET ADDRESS (If rural, give location) 4417 Glenmore Avenue	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July 13, 1894.	9. AGE (In years last birthday) 73	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John N. Suwalski	
14. MOTHER'S MAIDEN NAME Margaret Kraning		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Augustus W. Clark		ADDRESS (Same)		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive C-V disease with renal failure Pulmonary fibrosis Emphysema INTERVAL BETWEEN ONSET AND DEATH 15 yrs 20 yrs	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Recurrent colitis - malnutrition Dec. 19, 1967 to Dec. 17, 1967		21. I certify that (I) (this hospital) attended the deceased from Dec. 19, 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.	
22. SIGNATURE H. V. Harbold		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23. DATE SIGNED Dec. 20, 1967	
23. PHYSICIAN'S NAME (Type) H. V. HARBOLD		24. ADDRESS 4706 Harford Road		25. BALTIMORE Baltimore, Md.	
26. BURIAL CREMATION, REMOVAL (Specify) Burial		27. DATE 12/23/67		28. NAME OF CEMETERY or CREMATORY Moreland Memorial Cemetery	
29. LOCATION Baltimore, Md.		30. DATE REC'D BY HEALTH DEPT. DEC 22 1967		31. NAME OF REGISTRAR Charles Judge	
32. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS Baltimore, Md.		33. ADDRESS	

VR A15 (4)
25M 1/67

10-10-68

CERTIFICATE OF DEATH

10-10-68

Name of deceased [Name]		Date of birth [Date]		Place of birth [Place]		Date of death [Date]		Place of death [Place]	
Sex [Sex]		Race [Race]		Marital status [Status]		Cause of death [Cause]		Manner of death [Manner]	
Occupation [Occupation]		Education [Education]		Religion [Religion]		Social Security Number [Number]		Medical history [History]	
Family history [History]		Previous illnesses [Illnesses]		Surgical history [Surgery]		Hospitalization [Hospitalization]		Physician's statement [Statement]	
Burial or cremation [Burial]		Funeral home [Funeral]		Cemetery [Cemetery]		Burial date [Date]		Burial place [Place]	
Signature of physician [Signature]		Signature of registrar [Signature]		Signature of informant [Signature]		Signature of witness [Signature]		Signature of official [Signature]	
Date of certificate [Date]		Place of certificate [Place]		Official seal [Seal]		Official stamp [Stamp]		Official signature [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16474

CERTIFICATE OF DEATH

16467

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN lb Hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. JOSEPH HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21224 d. STREET ADDRESS 1144 Steelton Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Norman Edward CLARK		4. DATE OF DEATH Month Day Year December 18, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/17/67
9. AGE (In years lost birthday yrs.) 6		10. IF UNDER 1 YEAR Months Days Hours Min 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David H. Clark		14. MOTHER'S MAIDEN NAME Cynthia L. Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Mr. David H. Clark,		Address Balto. Md. 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory distress syndrome DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/17/ , 19 67 , to 12/18/ , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/18/ , 19 67 , and that death occurred at 5:45 M, from causes and on the date stated above.			
22a. SIGNATURE William		22b. DATE SIGNED 12/18/67	
22c. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/20/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REG'D BY REGISTRAR DATE DEC 22 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. This should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 11-66

10487

CERTIFICATE OF DEATH

1947

Name of Deceased		Date of Birth	
Sex		Race	
Marital Status		Occupation	
Cause of Death		Place of Death	
Time of Death		Signature of Physician	
Signature of Registrar		Date of Registration	

TO BE FILLED BY THE REGISTRAR

1. Name of Deceased

2. Date of Birth

3. Sex

4. Race

5. Marital Status

6. Occupation

7. Cause of Death

8. Place of Death

9. Time of Death

10. Signature of Physician

11. Signature of Registrar

12. Date of Registration

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

<div> <div>3</div> <div>1</div> </div> <div> <div>16475</div> <div>16468</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div>									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrow's Point			c. LENGTH OF STAY IN Ib		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PLANT DISPENSARY					d. STREET ADDRESS 1406 N. Fulton Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS First Middle Last					4. DATE OF DEATH December 27 1967 Month Day Year				
5. SEX Male		6. COLOR OR RACE Negroid		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-15-10		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Danville, Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME UNK.					14. MOTHER'S MAIDEN NAME UNK.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 228-16-6793		17. INFORMANT Mrs. Lillie Mae Clark 2414 Callow Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Coronary Occlusion DUE TO HCUD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Thos C. Patterson M.D. EXAMINER'S NAME (Type) THEO. C. PATTERSON					22. DATE SIGNED 12/27/67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		1-2-67		Balto. Nat'l Cem.			Baltimore, Maryland		
24. FUNERAL DIRECTOR MORTON & DYETT F.H. 1701 Laurens St.					25a. REC'D BY REGISTRAR DEC 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16476
16469

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Baltimore County General Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTO c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 8023 B Woodgate Ct., APT B e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cohen, Sol First Middle Last COHEN		4. DATE OF DEATH Month Day Year December 26 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-1905
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		9b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
10a. FATHER'S NAME MAX COHEN		10b. MOTHER'S MAIDEN NAME BESSIE ?	
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		12. SOCIAL SECURITY NO. 215-32-3634	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gen. ASCVD with Multiple Cerebrovascular Accidents Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4221		14. MRS. GUSSIE COHEN, 8023 WOODGATE CT., APT. B #7 INTERVAL BETWEEN ONSET AND DEATH	
15a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		15b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
16a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		16b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
17a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		17b. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-23 , 19 67 to 12-26 , 19 67 , that (I) (we) last saw the deceased alive on 12-26 , 19 67 , and that death occurred at 4:15pm from the causes and on the date stated above.			
22a. SIGNATURE DR. MORTON J. ELLIN		22b. DATE SIGNED 12-26	
22c. PHYSICIAN'S NAME (Type) DR. MORTON J. ELLIN		22d. ADDRESS 8629 LIBERTY ROAD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-31-67	
23c. NAME OF CEMETERY OR CREMATORY LUBOWITZ AGUDAS ACHIM		23d. LOCATION (City, town or county) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD		25a. REC'D BY REGISTRAR JAN 2 1968	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

1964

2091-9-1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16477
16470
CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> <u>421 Winters Avenue</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>421 Winters Avenue</u>		d. STREET ADDRESS <u>421 Winters Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mabel M. Coleman</u>		4. DATE OF DEATH Month Day Year <u>Dec. 29 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17 1890</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Catonsville Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Timothy I. Ebb</u>		14. MOTHER'S MAIDEN NAME <u>Martha Dorsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>217-01-1765D</u>	
17. INFORMANT <u>Mable Fletcher</u>		Address <u>85 Wintres Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ASCVD</u> (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			INTERVAL BETWEEN ONSET AND DEATH <u>6</u> MO. <u>20</u> yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>December 18, 1967</u> to <u>December 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>December 29, 1967</u> , and that death occurred at <u>8</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>James E. Rowe</u> M.D.		22b. DATE SIGNED <u>12/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James E. Rowe</u>		22d. ADDRESS <u>5550 Baltimore, National Pike</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 3, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Western Star</u>	23d. LOCATION (City, town or county) (State) <u>Catonsville Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Stetson D. Wilson</u> ADDRESS <u>1913 W. Baltimore St.</u>		25a. REC'D BY REGISTRAR <u>J. Charles J. J.</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles J. J.</u>	

10470

CERTIFICATE OF DEATH

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Handwritten signature

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 2.6 yrs		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY BALTO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234 d. STREET ADDRESS 1734 Red Oak Rd., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Halbert J. COLVIN		4. DATE OF DEATH Month December Day 22 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1908 9. AGE (In years lost birthday) 59 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Colvin		14. MOTHER'S MAIDEN NAME Laura Phillips	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-09-2013	
17. INFORMANT Catherine C. Colvin,		Address 1734 Red Oak Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Terminal broncho-pneumonia. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/20/ , 19 67 , to 12/22/ , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/22/ , 19 67 , and that death occurred at 4 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Dr. Gualberto C. Gokim Jr. M.D.		22b. DATE SIGNED 12/22/67	
22c. PHYSICIAN'S NAME (Type) Gualberto C. Gokim, Jr.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-26-1967	23c. NAME OF CEMETERY OR CREMATORY New Cathedral,	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.		25a. REC'D BY REGISTRAR DATE DEC 28 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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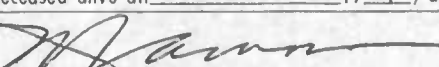
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
16479				16472			
CERTIFICATE OF DEATH							
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (1001 W. Joppa Rd.) Baltimore 21204			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. JOSEPH HOSPITAL				d. STREET ADDRESS 1001 W. Joppa Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SISTER MARY BERNARDINE, M.H.S.H. (CONLON)				4. DATE OF DEATH Month December Day 26 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 23, 1893		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 03 Days 03	IF UNDER 24 HRS. Hours 03 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Convent		11. BIRTHPLACE (County & State, or foreign country) New York, N.Y.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Conlon				14. MOTHER'S MAIDEN NAME Bridget Clark			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Convent Records, 1001 W. Joppa Rd. Towson			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease DUE TO (c) Thromboembolism, Thrombophlebitis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 25 19 67 , to Dec. 26 , 19 67 that (I) (we) lost the deceased alive on December 26 19 67 , and that death occurred at 3:05 AM , from causes on and the date stated above.							
22a. SIGNATURE  M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-26-67	
22c. PHYSICIAN'S NAME (Type) Dr. Ismael Jamora, M.D.				22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/28/1967		23c. NAME OF CEMETERY OR CREMATORY Convent Cemetery		23d. LOCATION (City or Town) (County) (State) 1001 W. Joppa Rd. Towson, Md.	
24. FUNERAL DIRECTOR Kernon Jamora				25a. REC'D BY REGISTRAR 4611 Park Heights Av. Balto. Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE DEC 28 1967							

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VR A15 (4)
25M 1/67

16480
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16473

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek d. STREET ADDRESS Rt. 2 Box 184 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BERNARD WEBSTER COOK		4. DATE OF DEATH Month Day Year 12 6 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-1886
9a. AGE (In years last birthday) 81		9b. IF UNDER 1 YEAR Months Days Hours Mins.	9c. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY TOBACCO	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM COOK	
14. MOTHER'S MAIDEN NAME MARIAN WEBSTER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. R13-38-3332		17. INFORMANT Address Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLI DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 years (c)		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Far advanced pulmonary tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12. 1, 1967 , to 12. 6, 1967 , that (I) (we) lost saw the deceased alive on 12. 6, 1967 , and that death occurred at 3:30 PM , from causes and on the date stated above.			
22a. SIGNATURE William Newcomer		22b. DATE SIGNED 12. 6. 67.	
22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent Mount Wilson, Maryland		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12-9-67	23c. NAME OF CEMETERY OR CREMATORY ST MARYS Cem	23d. LOCATION (City or Town) (County) (State) PISCATAWAY, P.E., MD.
24. FUNERAL DIRECTOR Shunt Funeral Home, Waldorf, Md.		25a. REC'D BY REGISTRAR DEC 11 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16481
CERTIFICATE OF DEATH
16474

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6739 Brookmont Dr.		d. STREET ADDRESS 6739 Brookmont Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ENRICO CORRELLI		4. DATE OF DEATH Month Day Year Dec. 7 1967		9. AGE (In years last birthday) 84 yrs.	
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 14, 1883		9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Giaconio Correlli		14. MOTHER'S MAIDEN NAME ??	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 717-07-6427		17. INFORMANT Mr. Herman Correlli 6739 Brookmont Dr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis and diabetes DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH one year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from November, 1967, to Dec, 1967, that (I) (we) last saw the deceased alive on 6 Dec 1967, and that death occurred at 1:30 P.M. from the causes and on the date stated above.		22a. SIGNATURE S E Proctor M.D.		22b. DATE SIGNED 8 Dec 67	
22c. PHYSICIAN'S NAME (Type) SE Proctor M.D.		22d. ADDRESS 104 W. Madison St 21201			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/11/67		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cem.	
23d. LOCATION (City, town or county) Balto. City, Md.		23e. REC'D BY REGISTRAR NFC 11 1967		23f. REGISTRAR'S SIGNATURE Richard Judge	
24. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. 1217 St. Paul St.		24a. ADDRESS		24b. REGISTRAR'S SIGNATURE	

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16482
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16475
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradshaw</u>				c. LENGTH OF STAY IN 1b <u>58 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>none</u>				d. STREET ADDRESS <u>Reynolds Road</u>			
3. NAME OF DECEASED (Type or print) <u>Catherine Gladys Creswell</u>				4. DATE OF DEATH <u>Dec. 26</u> 19 <u>67</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 5, 1903</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Joppa, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supr. Gas Mask Prod.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt- Ret.</u>		13. FATHER'S NAME <u>John Burke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>220-20-7068</u>		17. INFORMANT <u>Albert B. Creswell, Reynolds Rd., Bradshaw</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterio Sclerosis Hypertension</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Aug.</u> , 19 <u>62</u> to <u>Dec.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 11</u> , 19 <u>67</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William A. Tyson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>				22d. ADDRESS <u>Kingsville Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 29, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air Harford Md</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>				25a. REC'D BY REGISTRAR <u>DEC 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>	

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RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A13-1
30M REV. 7-68

16483		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		16476		
1. DECEASED-NAME (Type or print) First Middle Last Joseph G. Daniel				2a. DATE OF DEATH Month Day Year Dec. 28 1967		2b. HOUR 7:00 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 18, 1914		6. AGE (In years last birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 33 Sheraton Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrical Engineer		12b. KIND OF BUSINESS OR INDUSTRY Electric
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Randallstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 33 Sheraton Rd -	
14. FATHER'S NAME First Middle Last Leland - Daniel		15. MOTHER'S MAIDEN NAME First Middle Last Maggie Lee Windbourne				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 218-01-8082		17. INFORMANT Address Mrs. Gladys Daniel Randallstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH. 30 min						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>67</u> , to <u>Dec. 28</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Dec. 28</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Wm. E. Martin M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 12-28-67		
22d. PHYSICIAN'S NAME (Type) <u>Wm. E. MARTIN, M.D.</u>				22e. ADDRESS <u>Randallstown Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-31-67		23c. NAME OF CEMETERY OR CREMATORY Wards Chapel		23d. LOCATION (City or Town) (County) (State) Randallstown Md.
24. FUNERAL DIRECTOR <u>Harry W. Haight</u> ADDRESS <u>Sykesville, Md.</u>				25a. REC'D BY REGISTRAR DATE JAN 3 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

1848

REPORT OF THE

Commissioner of the General Land Office
for the year ending June 30, 1848

ALBANY: PUBLISHED BY J. B. LEECH, 1848.

Items 23c Film G397 2/7/68 kk

CERTIFICATE OF DEATH

16477

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY — ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30-4	
c. LENGTH OF STAY IN lb 35yrlmth16dys			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2827 East Chase Street	
3. NAME OF DECEASED (Type or print) Walter First Middle Last		4. DATE OF DEATH December 26 Month Day Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1914 53 yrs.
9. AGE (In years lost birthday) 53		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frederick Danker		14. MOTHER'S MAIDEN NAME Hattie Amelia Grubbs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest. DUE TO (b) Metastatic Ca. DUE TO (c) Transfusion Allergic Reaction. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that xxx (this hospital) attended the deceased from Oct. 29 , 19 32 , to 12/26 , 19 67 , that he (we) last saw the deceased alive on 12/26 , 19 67 , and that death occurred at 1054 AM, from causes and on the date stated above.			
22a. SIGNATURE Robert Fisher		22b. DATE SIGNED 12/26/67	
22c. PHYSICIAN'S NAME (Type) Robert Fisher		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Anatomy Board of Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR		25a. REG'D BY REGISTRAR JAN 5 1968 DATE	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL TOWSON</u>		c. LENGTH OF STAY IN lb <u>20 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>1 E. UNIVERSITY PARKWAY</u> <u>Appt. 104</u>	
3. NAME OF DECEASED (Type or print) <u>WALTER JAMES DAVIS</u>		4. DATE OF DEATH Month <u>December</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-06-86</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WORK IN COAL MINES</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ARCHIBALD PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>FRANK DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>057-34-2619</u>	
17. INFORMANT <u>M. FABISZAK</u>		Address <u>B.B.M.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> DUE TO (b) <u>Extensive carcinoma, lung, left</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital)-attended the deceased from <u>Nov. 23</u> , 19 <u>67</u> , to <u>Dec. 12</u> , 19 <u>67</u> , that (we) last saw the deceased alive on <u>Dec. 12</u> , 19 <u>67</u> , and that death occurred at <u>3:40 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Marlean S. Femi</u>		22b. DATE SIGNED <u>Dec. 12, 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>NASTACIA FABIE</u>		22d. ADDRESS <u>GBMC - 6701 N. Charles St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-15-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>PECKVILLE LACKAWANNA CO., PA.</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Inc.</u>		25a. REC'D BY REGISTRAR <u>1217 St. Paul St.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 15 1967</u>	

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UNITED STATES OF AMERICA

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Graham & Co
Hunters Fabrics

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
16486			
16479			
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 3mth27dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillsdie, Maryland		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1222 - 53rd Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George William DeBinder Sr.		4. DATE OF DEATH Month December Day 4 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1908
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 4 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME George W. DeBinder		14. MOTHER'S MAIDEN NAME Libby Stanton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes 1928-1932		16. SOCIAL SECURITY NO. 579-01-1153	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from Aug. 7, 1967 to Dec. 4, 1967 , that (X) (we) last saw the deceased alive on Dec. 4, 1967 , and that death occurred at p. M, from causes on and on the date stated above.			
22a. SIGNATURE Anthony G. Young, M.D.		22b. DATE SIGNED 12-4-67	
22c. PHYSICIAN'S NAME (Type) Anthony G. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/8/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore, Baltimore Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE DEC 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

SHIPPED TO: L. W. HERRING FUNERAL HOME, 15 MAIN ST. SMITHFIELD, VIRGINIA

16487		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		16480	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		MARYLAND c. LENGTH OF STAY IN lb 14 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - 21222	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 209 MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE N. DELK		First Middle Last		4. DATE OF DEATH Month DECEMBER Day 8 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/99	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (County & State, or foreign country) ISLE OF WRIGHT COUNTY, VIRGINIA U.S.A.	
13. FATHER'S NAME RUBEN DELK		14. MOTHER'S MAIDEN NAME IDA CORNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 216 10 17 27		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) CEREBRAL VASCULAR ACCIDENT, CLINICAL DUE TO (c) RECENT				INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) ARTERIOSCLEROTIC HEART DISEASE. ADENOCARCINOMA RIGHT KIDNEY				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (X) (this hospital) attended the deceased from 11/24/67 , 19__, to 12/8/67 , 19__, that (X) (we) last saw the deceased alive on 12/8/67 , 19__, and that death occurred at 2:10 AM from causes and on the date stated above.					
22a. SIGNATURE <i>John D. Talbert</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/8/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-12-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Bapt. Ch. Cem. Smithfield, Va.	
23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR		ADDRESS MORTEN & DYETTE FUNERAL HOME		25a. REC'D BY REGISTRAR 11 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
1701 LAURENS ST. BALTIMORE, MD.					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-15 (4)
30M REV. 1/68

16488										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16481																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last Annie MARIAN Dell										Month Day Year Dec. 31, 1967										M																													
3. SEX Female										4. RACE White										5. DATE OF BIRTH Feb. 23, 1888										6. AGE (In years last birthday) 79 YRS.										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Md.										7b. CITIZEN OF WHAT COUNTRY? U. S. A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md.																			
10. CITY OR TOWN OF DEATH Randallstown										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Liberty Road										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife										12b. KIND OF BUSINESS OR INDUSTRY U. S. A.																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY Baltimore										13c. CITY OR TOWN Randallstown										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER Liberty Road 031									
14. FATHER'S NAME First Middle Last William A. Crooks										15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth - Claggett										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No										16b. SOCIAL SECURITY NO. —										17. INFORMANT MR. J. HARMAN Crooks - Randallstown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4201 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 1945 to 12/31/1967, that (I) (we) last saw the deceased alive on 12/31/1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Wm. E. Martin, M.D.										22c. DATE SIGNED																													
22d. PHYSICIAN'S NAME (Type) Wm. E. Martin, M.D.										22e. ADDRESS Randallstown Md																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 1-3-68										23c. NAME OF CEMETERY OR CREMATORY Wards Chapel Cemetery										23d. LOCATION (City or Town) (County) (State) Baltimore County, Md.																			
24. FUNERAL DIRECTOR HARRY W. HIGHT Sykesville, Md.										25a. REC'D BY REGISTRAR DATE JAN 5 1968										25b. REGISTRAR'S SIGNATURE J. Charles J. J.																													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b ? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. JOSEPH HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 601 E. Joppa Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Alice ALSTON DEVASHER					4. DATE OF DEATH Month December Day 19 Year 19 67				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 31, 1887		9. AGE (In years lost birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Kansas CITY, MISSOURI			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William ALSTON					14. MOTHER'S MAIDEN NAME CATHERINE O'BRIEN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Wm. A. DeVasher 14 W. Cold Spring LA.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5721 IMMEDIATE CAUSE (a) Broncho-pneumonia of both lungs DUE TO Acute Peritonitis, rupture of diverticulum of the colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/18/ , 19 67 to 12/19/ , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/19/ , 19 67 , and that death occurred at 2:15 PM , from causes on and on the date stated above.									
22a. SIGNATURE I. Cilliani					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 12/19/67	
22c. PHYSICIAN'S NAME (Type) I. Cilliani, M.D.					22d. ADDRESS 7620 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 12-23-67		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY			23d. LOCATION (City or Town) (County) (State) BALTO. Md.		
24. FUNERAL DIRECTOR ADDRESS Wm. Cook - Brooks, Inc. 1217 ST. PAUL ST.					25a. REC'D BY REGISTRAR DATE DEC 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
16483											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6702 Linden Avenue</u>					d. STREET ADDRESS <u>6702 Linden Avenue</u>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Florence E.</u> Middle <u>Dieter</u> Last <u></u>					4. DATE OF DEATH Month <u>Dec.</u> Day <u>30</u> Year <u>1967</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 29, 1915</u>		9. AGE (In years last birthday) <u>52</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John Cook</u>					14. MOTHER'S MAIDEN NAME <u>Mary Pfarr</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>John Dieter - 6702 Linden Ave. - 21206</u>			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4201 DUE TO (b) <u>Arteriosclerotic cardio-vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>disease</u> DUE TO (c) <u>disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>4 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 29, 1966</u> to <u>Dec 30, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 18, 1967</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles M. Kerr</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-31-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Charles M. Kerr</u>					22d. ADDRESS <u>6801 Belair Rd Balto Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-3-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>					
24. FUNERAL DIRECTOR <u>John C. Miller Inc-6415 Belair Rd.-21206</u>					25a. REC'D BY REGISTRAR <u>JAN 8 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16484

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL BALTO.</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>Ellicott City</u> <u>13.2</u>		d. STREET ADDRESS <u>1 Woodview Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater BALTO. Medical Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Stephen CHARLES DiStefano</u>		4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-19-20</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Filling Station</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>CHARLES DiStefano</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. Catanzarher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>220-04-0490</u>	
17. INFORMANT <u>Helen K. DiStefano - Same</u> <u>M. FABISZAK</u> <u>G.B.M.C.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, large & diffuse metastases</u> DUE TO (b) <u>163 x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>72 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11:47 p.m.</u> <u>Dec. 11 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>he</u> (this hospital) attended the deceased from <u>December 2, 1967</u> , to <u>December 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>December 11 1967</u> , and that death occurred at <u>11:47 p.m.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Anastacia E. Fabie</u>		22b. DATE SIGNED <u>Dec. 11, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ANASTACIA E. FABIE</u>		22d. ADDRESS <u>GREATER BALTIMORE MED. CENTER</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/15/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Witzke R. D. - 4101 Edmondson Av.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items 8 & 9 Film G397 2/8/68 185			
16492			
CERTIFICATE OF DEATH			
17888			
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 515 PRISCILLA STREET	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle THOMAS Last DIX		4. DATE OF DEATH Month DECEMBER Day 3 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 6 67 1892
9. AGE (In years last birthday) 72 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) PARKSLEY, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W. DIX		14. MOTHER'S MAIDEN NAME JBANETTE WESSELLS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 225 18 3216	
17. INFORMANT CLIN. REC., VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CARCINOMA OF THE PROSTATE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 25 19 67 to Dec. 3 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 3 19 67 , and that death occurred at 12:10p M, from causes and on the date stated above.			
22a. SIGNATURE <i>Henry M. Johnson</i> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 12/3/67	
22c. PHYSICIAN'S NAME (Type) ISABELITA Y CORDOBA		22d. ADDRESS VAH, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12/19/67	23c. NAME OF CEMETERY OR CREMATORY Parksley Cemetery	23d. LOCATION (City or Town) (County) (State) PARKSLEY, VIRGINIA
24. FUNERAL DIRECTOR Henry Johnson Funeral Home		25a. REC'D BY REGISTRAR FEB 2 1968	
ADDRESS Parksley, Virginia		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND

BALTIMORE

SALISBURY

8 DAYS

FORT HOWARD

515 PRISCILLA STREET

VETERANS ADMINISTRATION HOSPITAL

DECEMBER 3, 1967

DIX

THOMAS

ARTHUR

MALE WHITE

CARPENTER

JOHN W. DIX

JEANETTE WESSLETS

CIV. REC. VAIL. FT. HOWARD, MD.

335 18 3216

YES

PREVIOUSLY

PREVIOUSLY

Dec. 3, 1967

Dec. 3, 1967

Dec. 3, 1967

PARKLEY, VIRGINIA

PARKLEY, VIRGINIA

PARKLEY, VIRGINIA

PARKLEY, VIRGINIA

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 11, Film G396 1/16/68 kr
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16493

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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN Ib Dundalk 03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2903 Liberty Parkway		d. STREET ADDRESS 2903 Liberty Parkway	
3. NAME OF DECEASED (Type or print) Margaret Celestia Dohner		4. DATE OF DEATH Month December Day 30 , Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1898
9. AGE (In years last birthday) yrs. 69		10. IF UNDER 1 YEAR Months 6 Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clark Helwig		14. MOTHER'S MAIDEN NAME Grace Adams Edwards	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-54-6010	
17. INFORMANT Abraham S. Dohner		Address 2903 Liberty Parkway	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Carditis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		22. DATE SIGNED	
EXAMINER'S NAME (Type) M.B. Davis, M.D.		Address (Street, city, town, or county) 6800 Mornington Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/3/68	
23c. NAME OF CEMETERY OR CREMATORY Crestlawn Gardens		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md.		25a. REC'D BY REGISTRAR DATE JAN 5 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge			

15ME (5)
6M 1/67

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS 18 North Mount Street	
3. NAME OF DECEASED (Type or print) Helen J. Dorsey		4. DATE OF DEATH Month December Day 12 Year 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1897
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Domestic		10b. KIND OF BUSINESS OR INDUSTRY Put Family	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Archie Johnson		14. MOTHER'S MAIDEN NAME CHRISTINIA HOWARD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-10-0900	
17. INFORMANT Records: Spring Grove		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Bronchial, Right Lower Lobe 491X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Ht. Dis with congestive failure			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from Dec. 11, 1967 , to Dec. 12, 1967 , that (we) last saw the deceased alive on Dec. 12, 1967 , and that death occurred at 7:00 PM , from causes and on the date stated above.			
22a. SIGNATURE Anthony J. Young, M.D.		22b. DATE SIGNED Dec. 13, 1967	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12/15/67	23c. NAME OF CEMETERY OR CREMATORY not known	23d. LOCATION (City or town) (County) (State) Baltimore
24. FUNERAL DIRECTOR Marshall P. Lynn 638 N. G. Linn St		25a. REC'D BY REGISTRAR DEC 14 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE [Signature]	

16494

16486

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STATE OF TEXAS

County of _____

City of _____

Know all men by these presents, that _____

of the County of _____ State of Texas, for and in consideration of the sum of _____ Dollars, to _____ of the County of _____ State of Texas, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said _____ of the County of _____ State of Texas, all that certain _____

containing _____ Acres, more or less, situated in the County of _____ State of Texas, to have and to hold unto the said _____ his heirs and assigns forever.

Given under my hand and seal of office this _____ day of _____ A.D. 19____

Notary Public in and for the State of Texas

My commission expires this _____ day of _____ A.D. 19____

Witness my hand and seal of office this _____ day of _____ A.D. 19____

Notary Public in and for the State of Texas

My commission expires this _____ day of _____ A.D. 19____

Notary Public in and for the State of Texas

My commission expires this _____ day of _____ A.D. 19____

Notary Public in and for the State of Texas

My commission expires this _____ day of _____ A.D. 19____

Notary Public in and for the State of Texas

My commission expires this _____ day of _____ A.D. 19____

Notary Public in and for the State of Texas

My commission expires this _____ day of _____ A.D. 19____

Notary Public in and for the State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY BALTIMORE (TOWSON) MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ---				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b 52 hr 15 min		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE (TOWSON) 3004				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER					d. STREET ADDRESS 2026 W FAYETTE STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First James		Middle Grafton		Last Dorsey, 111		4. DATE OF DEATH Month 12 Day 24 Year 1967	
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-22-67		9. AGE (In years last birthday) yrs. 2 Months 4 Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) BALTO. MD		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME James Grafton Dorsey, Jr.					14. MOTHER'S MAIDEN NAME BAFEFOOT				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT INFANT BIRTH INFORMATION				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock + respiratory arrest + pneumonia DUE TO (b) midgut volvulus - intestinal necrosis DUE TO (c) Ruptured omphalocele - congenital PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Peritonitis									
INTERVAL BETWEEN ONSET AND DEATH									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12/22 , 19 67 to 12/24 , 19 67 , that (I) (we) last saw the deceased alive on 12/24 , 19 67 , and that death occurred at 9:35 M, from the causes and on the date stated above.									
22a. SIGNATURE David					22b. DATE SIGNED 12/24/67				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 12-28-67		23c. NAME OF CEMETERY OR CREMATORY Mt Auburn		23d. LOCATION (City, town or county) (State) Baltimore Md		
24. FUNERAL DIRECTOR Mrs Francis A. Hemslay					25a. REC'D BY REGISTRAR JAN 3 1968		25b. REGISTRAR'S SIGNATURE Francis Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16496					16486				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Manor</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Manor</u> 03.1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5901 Montgomery St.</u>					d. STREET ADDRESS <u>5901 Montgomery St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maud</u> T. Middle <u>Drain</u> Last					4. DATE OF DEATH Month <u>Dec.</u> 19 <u>67</u> Day Year				
5. SEX <u>F</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7, 1877</u>		9. AGE (In years last birthday) yrs. <u>90</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Bal to., Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Houck</u>					14. MOTHER'S MAIDEN NAME <u>Mary McClymont</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Lela Simpson</u> Address <u>5901 Montgomery St.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Cerebral</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 9, 1947</u> , to <u>12/19, 1967</u> , that (I) (we) last saw the deceased alive on <u>12/18, 1967</u> , and that death occurred at <u>12/19, 1967</u> M, from causes and on the date stated above.									
22a. SIGNATURE <u>John P. Urlock Jr</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/19/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>John P. Urlock, Jr.</u>					22d. ADDRESS <u>1227 Washington Blvd.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>					25a. REC'D BY REGISTRAR DATE <u>DEC 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

1948

DEPARTMENT OF DEATH

1948

1948



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16497

16489

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1018 MARKS WORTH ROAD		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE d. STREET ADDRESS 1018 MARKS WORTH ROAD	
3. NAME OF DECEASED (Type or print) MICHAEL DUFFY First Middle Last		4. DATE OF DEATH DEC. 29 1967 Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 4 1869 9. AGE (In years last birthday) 98 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY B.K.O. R.R.	11. BIRTHPLACE (County & State, or foreign country) IRELAND
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 4221 DUE TO (b) Arteriosclerotic Cardio-vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5 days years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from May 19 61 , to Dec. 19 67 , that (I) (was) saw the deceased alive on Jan. 28 19 67 , and that death occurred at 4:30 from the causes and on the date stated above.			
22a. SIGNATURE Leo J. Gaver, M.D.		22b. DATE SIGNED 12/29/67	
22c. PHYSICIAN'S NAME (Type) Leo J. Gaver, M.D.		22d. ADDRESS 1 Mallow Hill Ave., Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JAN. 3, 1968	23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	23d. LOCATION (City, town or county) (State) BALTO. MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE Harry K. Witten		25a. REC'D BY REGISTRAR DATE JAN 3 1968	
ADDRESS 4101 EDMONDSON BALTO		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN lb <u>2 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE COUNTY GENERAL HOSP.</u>		d. STREET ADDRESS <u>116 W. Martin St.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Oneita</u> Middle <u>S.</u> Last <u>Eckersley</u>		4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1888</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>Housewife</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (County & State, or foreign country) <u>PA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert Sechrist</u>	
14. MOTHER'S MAIDEN NAME <u>Emma Kemp</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>913-01-75458</u>		17. INFORMANT <u>Daughter Julia Cross</u> Address <u>Woodstock - Md. Granite Mobile Ct.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diffuse edema + acute passive congestion of lungs</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (chotomy)
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 17, 1967</u> , to <u>Dec. 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec. 19, 1967</u> , and that death occurred at <u>8:15 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Gracito V. Patricia</u>		22b. DATE SIGNED <u>Dec. 19, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gracito V. Patricia</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Dec. 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wheaton Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Snow Hill, Md.</u>
24. FUNERAL DIRECTOR <u>Deans Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DEC 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1843

CERTIFICATE OF DEATH

1843

James Thomas
1843

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16499											
16491											
1. PLACE OF DEATH a. COUNTY BALTO MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTO					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX				03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 213 S. TAYLOR						d. STREET ADDRESS 213 S. TAYLOR				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MILDRED C. EDELL						4. DATE OF DEATH Month DEC. Day 24 Year 1967					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 21, 1892		9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BALTO. MD.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ANDREW STUCKRATH						14. MOTHER'S MAIDEN NAME ELIZ. ROSE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 216-09-6175		17. INFORMANT ALBERT EDELL Address ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure DUE TO Heart failure, chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Hypertensive Cardiovascular disease (c) probably cancer of unknown origin.										INTERVAL BETWEEN ONSET AND DEATH 2 days 2 months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) probably cancer of unknown origin.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 12, 1964 to December 23, 1967 , that (I) (we) last saw the deceased alive on December 23, 1967 , and that death occurred at 1 P.M. from causes and on the date stated above.											
22a. SIGNATURE Eugene C. Baumann						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-26-67			
22c. PHYSICIAN'S NAME (Type) Eugene C. Baumann						22d. ADDRESS 413 Eastern Ave. Baltimore 21, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/28/67		23c. NAME OF CEMETERY OR CREMATORY DAK LAWN				23d. LOCATION (City or Town) (County) (State) BALTO. MD			
24. FUNERAL DIRECTOR J.G. CONNELLY SONS ADDRESS 300 MACE						25a. REC'D BY REGISTRAR DEC 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (1)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
16500		16492	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> 03-1	
c. LENGTH OF STAY IN 1b <u>15 MRS.</u>		d. STREET ADDRESS <u>17 BRIARWOOD RD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHANGRI-LA HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELsie</u> First Middle Last <u>O. Ehlers</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/83</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13. FATHER'S NAME <u>Alfred H. Milburn</u>		14. MOTHER'S MAIDEN NAME <u>Emily J.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Ralph M. Ehlers</u>		Address <u>17 Briarwood Rd</u> <u>21228</u>	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Unemia</u> DUE TO (b) <u>Nephrosclerosis</u> (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Glaucoma - Diabetes - Fresh G.I. Bleeding</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-6-</u> , 19 <u>67</u> , to <u>12-25-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-26-1967</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Cesar Valle Caverro</u>		22b. DATE SIGNED <u>12-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERO</u>		22d. ADDRESS <u>8629 Liberty Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. Co. Md</u>
24. FUNERAL DIRECTOR <u>C.S. MacNabb</u>		25a. REC'D BY REGISTRAR <u>JAN 2 1968</u>	
ADDRESS <u>Catonville Md 21224</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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UNCLASSIFIED

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[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
16501 Item 9 Film G396 1/2/68 JK													
CERTIFICATE OF DEATH													
16493													
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1 yr 10 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u> 03-7							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Haven Nursing Home</u>						d. STREET ADDRESS <u>Gun Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Theodore Eichhorn</u>						4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>1967</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>11-26-1884</u>		9. AGE (In years last birthday) yrs. <u>82</u>		IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min. <u>67</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>St. Louis Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Otto Eichhorn</u>						14. MOTHER'S MAIDEN NAME <u>Maria Wolfe</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>218-18-2147</u>		17. INFORMANT Address <u>Marguerite Leutner 7320 Windsor Mill Rd.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 MYOCARDIAL INFARCTION</u> DUE TO (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>DISEASE</u>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>3/14</u> , 19 <u>66</u> , to <u>12/17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/17</u> , 19 <u>67</u> , and that death occurred at <u>10</u> M, from causes and on the date stated above.													
22a. SIGNATURE <u>Dr. John H. Shaw</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>12/18/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. John H. Shaw</u>						22d. ADDRESS <u>5800 Edmondson Avenue Balto Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Woodlawn Balto Md.</u>					
24. FUNERAL DIRECTOR <u>Loring Byers 8728 Liberty Rd Randallstown</u>						25a. REC'D BY REGISTRAR DATE <u>DEC 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 39yr 4mth	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1525 Clement Street	
3. NAME OF DECEASED (Type or print) Julia		4. DATE OF DEATH Month December Day 1 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 219-54-3107T	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: 170x IMMEDIATE CAUSE (a) Undetermined, DUE TO Bronchopneumonia, Left Lower Lobe, org, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Metastatic carcinoma, probable, DUE TO (c) Carcinoma of the left breast, probable		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 month 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus; Hypertensive, Carteriosclerotic CVHD		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Aug. 1, 1967 to Dec. 1, 1967 that (2) (we) last saw the deceased alive on Dec. 1, 1967 , and that death occurred at 11:30 M, from causes and on the date stated above.			
22a. SIGNATURE Anthony J. Young, M.D.		22b. DATE SIGNED 12-1-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Anatomy Board of Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

1-2-68 mt 16503		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		16495	
1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 5646 Govane Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ralph William Engle		4. DATE OF DEATH Month Day Year December 20 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH August 25, 1905		9. AGE (In years lost birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Avis Truck Rental		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles C. Engle		14. MOTHER'S MAIDEN NAME Laura ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service) --- 166-01-0233		17. INFORMANT Address Mary M. Engle (Wife) Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Abdominal Ruptured aortic aneurysm		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Dec. 13, 19 67, to Dec. 20, 19 67, that (I) (we) last saw the deceased alive on Dec. 20, 19 67, and that death occurred at 11:40 PM, from causes and on the date stated above.					
22a. SIGNATURE Lucas C. Vidhyaphum		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-20-67	
22c. PHYSICIAN'S NAME (Type) Lucas C. Vidhyaphum, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/1967		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR Eugenia K. Seitz		ADDRESS 5209 York Rd. Balto. 21212		25a. REC'D BY REGISTRAR DEC 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

10487

RECORD OF 11-11

10487

RECORD OF 11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
16504			
CERTIFICATE OF DEATH			
16496			
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
PROFESSIONAL HOUSE, 133 SLADE AVENUE		3900 N. CHARLES STREET	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last FLORA B. ENNIS		Month Day Year DECEMBER 27, 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 9, 1888
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALEXANDER BECKHOFFER		14. MOTHER'S MAIDEN NAME REBECCA STRAUS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-12-8907	
17. INFORMANT MR. PAUL PALMBAUM, 6701 PARK HIGHTS. AVE.		Address APT. 3D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Systemic thrombosis of middle cerebral artery - original thrombosis - 4 weeks prior to death DUE TO (b) Arteriosclerotic cerebrovascular Dis. - sur. op. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/20, 1953 to 12/27, 1967 , that (I) (we) last saw the deceased alive on 12/21, 1967 , and that death occurred at 11:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. J. Elliott Levi		22b. DATE SIGNED 12/28/67	
22c. PHYSICIAN'S NAME (Type) Dr. J. ELLIOT LEVI		22d. ADDRESS 222 W. COLD SPRING LANE	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-28-67	
23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD		25a. REC'D BY REGISTRAR JAN 2 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	

10000

UNITED STATES

BALTIMORE

1000 N. CHARLES STREET

PROFESSIONAL BUILDING, 100 N. BALTIMORE

RECEIVED

FROM

SECTION 1, 1912

RECEIVED

BALTIMORE, MARYLAND

AT HOME

RECEIVED

CORRECTION

ALL VOTES

1912-13-14

1912-13-14

1912-13-14

1912-13-14

1912-13-14

1912-13-14

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VR A15 (4)
20 M 1/66

16503 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
16497									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Baltimore			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1209 Overbrook Road					d. STREET ADDRESS 1209 Overbrook Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LENA Middle H. Last EVANS					4. DATE OF DEATH Month December Day 15 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 10, 1895		9. AGE (In years last birthday) yrs. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Switzerland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Allard					14. MOTHER'S MAIDEN NAME Unk.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Magdalene Behr			Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. with metastasis to abd lymphatics (b) (c) INTERVAL BETWEEN ONSET AND DEATH 8 months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive C-V disease								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec 12, 1967 to Dec 15, 1967 , that (I) (we) last saw the deceased alive on Dec 12, 1967 , and that death occurred at 2:30 PM , from causes and on the date stated above.									
22a. SIGNATURE H. K. Harbold M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec 16, 1967			
22c. PHYSICIAN'S NAME (Type) H. K. HARBOLD MD				22d. ADDRESS 4706 Harford Road Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/18/67.		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214					25a. REC'D BY REGISTRAR DATE DEC 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

18202

10481

REPUBLIC OF DENMARK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16506		16498	
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville c. LENGTH OF STAY IN lb life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2706 Taylor avenue		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville d. STREET ADDRESS 2706 Taylor avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET EVANS First Middle Last		4. DATE OF DEATH Dec 31 1967 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 9 1877
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Meis		14. MOTHER'S MAIDEN NAME Margaret *****	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Cerebral arteriosclerosis DUE TO (c) 20 yrs		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 5, 1967 , to Dec 31, 1967 , that (I) (we) last saw the deceased alive on Dec 31 1967 , and that death occurred at 5:00 M, from causes and on the date stated above.			
22a. SIGNATURE S. Elliot Harris M.D.		22b. DATE SIGNED 1/2/68	
22c. PHYSICIAN'S NAME (Type) S. Elliot Harris M.D.		22d. ADDRESS 8100 Hafford Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/3/68	
23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road		25a. REC'D BY REGISTRAR DATE JAN 3 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge			

10000

CERTIFICATE OF DEATH

1900

Baltimore

Maryland

John H. H. H.

Parkville

1890

Parkville

2700 Taylor Avenue

2700 Taylor Avenue

Dec 31

EVANS

MARGARET

Feb 2 1900

Maryland

John H. H. H.

MARGARET

John H. H. H.

Family Record

John H. H. H.

John H. H. H.

John H. H. H.

8100 Hester Rd.

Baltimore, Maryland

Mr. Carmel Conn.

John H. H. H.

John H. H. H.

John H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
16507										
16499										
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville, Md.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville - 21234 03-1					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2611 Putty Hill Rd. Apt "6"					d. STREET ADDRESS 2611 Putty Hill Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle LAMBERT Last FADER					4. DATE OF DEATH Month December Day 28 , Year 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 8, 1892		9. AGE (In years last birthday) 75 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Manager		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Fader					14. MOTHER'S MAIDEN NAME Minnie Bahr					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 216-05-9488					INFORMANT Address Mrs. Fannie Fader-2611 Putty Hill Rd.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute dilatation of the heart 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 0 4 months										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from September , 19 67 , to Dec. 28 , 19 67 , that I last saw the deceased alive on December 28 , 19 67 , and that death occurred at 11 a. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 516 Cathedral St., Baltimore, Md. DATE SIGNED 12/29/67 ACTUAL SIGNATURE Ernest B. Marr M.D. PHYSICIAN'S NAME (Type) Ernest Marr, M.D. 516 Cathedral St. Dec. 29, 1967										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 2, 1968		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park			22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE H. Sander & Sons, Inc., Balto., Md.					24a. REC'D BY REGISTRAR DATE JAN 2 1968		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

1939

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

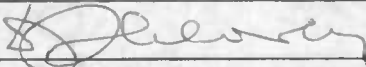
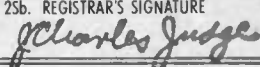
VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16508					16500				
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Codd Convalescent Home</i>					d. STREET ADDRESS <i>7914 Knollwood Road</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH Month Day Year <i>December 15, 1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>November 2, 1891</i>		9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John A. McMahon</i>				14. MOTHER'S MAIDEN NAME <i>Alice Shannessy</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Family records</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL HEMORRHAGE</i> <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <i>6 MOS.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>AUG 10</i> , 19 <i>67</i> , to <i>DEC 15</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>DEC 14</i> , 19 <i>67</i> , and that death occurred at <i>12</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>T. C. Siwinski</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/18/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>T. C. SIWINSKI</i>				22d. ADDRESS <i>206 W. PENNA. AV. TOWSON MD.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 18, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>				ADDRESS		25a. REC'D BY REGISTRAR DATE <i>DEC 21 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

16509

CERTIFICATE OF DEATH

16501

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8402 Beryl Road		e. STREET ADDRESS 8402 Beryl Road	
3. NAME OF DECEASED (Type or print) First ETHEL Middle MARIE Last FEETE		4. DATE OF DEATH Month December Day 4 Year 19 67.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1912.
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 5 Days 12 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired C. & P. Telephone Co.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME George Andrews		14. MOTHER'S MAIDEN NAME Estelle Benson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-03-6957	
17. INFORMANT Mr. Vernon Feete		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1750 IMMEDIATE CAUSE (a) Cerebral hemorrhage, overman with Metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1960 (74)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1953 , 19 12-3 , 19 67 , that (I) (we) last saw the deceased alive on 12-3 19 67 , and that death occurred at 5:20 AM , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 12-4-67	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph Skloven		22d. ADDRESS 7122 Harford Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/7/67.	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DEC 5 1967	25b. REGISTRAR'S SIGNATURE 

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1950

DEPARTMENT OF HEALTH

1950

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Division of Health

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VR A15 (4)
25M 1/67

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 112 SCOTT STREET	
3. NAME OF DECEASED (Type or print) First NOBLE Middle ELZAPHION Last FISHER		4. DATE OF DEATH Month DECEMBER Day 15 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGROID	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/12/25
9. AGE (In years last birthday) yrs. 42		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY STEEL	
11. BIRTHPLACE (County & State, or foreign country) GRASONVILLE, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT FISHER		14. MOTHER'S MAIDEN NAME ARRIE BOWLING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 218 20 6821	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF ESOPHAGUS DUE TO 150 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/12/67 , 19__, to 12/15/67 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/13/67 19__, and that death occurred at 7:30 PM , from causes and on the date stated above.			
22a. SIGNATURE George Dudas		22b. DATE SIGNED 12/16/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, MD		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 20, 1967	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Wm. March Funeral Home		25a. REC'D BY REGISTRAR DEC 18 1967	
ADDRESS 928 E. North Ave. Baltimore, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

ERGONOMICS

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VETERANS ADMINISTRATION HOSPITAL

THIS BOOK IS NOT TO BE REPRODUCED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, WITHOUT PERMISSION IN WRITING FROM THE PUBLISHERS.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16503

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3mths.18dys.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 21222 Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS 2151 Coralhorn Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Star		First Middle Last Flanagan		4. DATE OF DEATH Month Day Year Dec. 26 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1912	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
13. FATHER'S NAME Russell Martin		14. MOTHER'S MAIDEN NAME Mary Varner		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-5558		17. INFORMANT Records: Spring Grove State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma to right temporal lobe DUE TO (b) Metastatic, well differentiated adeno- DUE TO (c) the gastrointestinal tract, probable Well differentiated adenocarcinoma, from 6 months 159x					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (x) (this hospital) attended the deceased from Sept. 8, 1967 , to Dec. 26, 1967 , that (x) (we) last saw the deceased alive on Dec. 26, 1967 , and that death occurred at 5:00M , from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED P.		22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.	
22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228		22e. REC'D BY REGISTRAR DATE JAN 3 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 30, 1967		23c. NAME OF CEMETERY OR CREMATORY FLANAGAN CEMETERY	
23d. LOCATION (City or Town) (County) (State) DRY FORK W. VA.		24. FUNERAL DIRECTOR BYRON KIGHT			
24a. ADDRESS CUMBERLAND, MD.		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16512

16504

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>		c. LENGTH OF STAY IN 1b <u>16 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6004 Charlesmead Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth M. Folckemer</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 16 1926</u> 91 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NURSING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Springfield, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13. FATHER'S NAME <u>Samuel S. Folckemer</u>		14. MOTHER'S MAIDEN NAME <u>Ann Harper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1917-18</u>		16. SOCIAL SECURITY NO. <u>275-30-649</u>	
17. INFORMANT <u>Berenice T. Wainwright</u>		Address <u>6004 Charlesmead Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO <u>Arteriosclerotic cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>19</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>December, 1966</u> , to <u>Dec 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 26, 1967</u> , and that death occurred at <u>12:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Chas. W. Wainwright</u>		22b. DATE SIGNED <u>12/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chas. W. Wainwright</u>		22d. ADDRESS <u>9 E. Chase St. Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>12-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co. 4905 York Rd. Balto.</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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EXHIBIT OF DEATH

John W. ...

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John W. ...

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN lb 4 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 107 Lampport Road		e. STREET ADDRESS 107 Lampport Road	
3. NAME OF DECEASED (Type or print) Charles Calvin Folkert		4. DATE OF DEATH Month Dec. Day 16 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 9, 1890
9. AGE (In years last birthday) yrs. 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed Grocer	
11. BIRTHPLACE (County & State, or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Folkert		14. MOTHER'S MAIDEN NAME Elizabeth Chritzendahler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-22-9985	
17. INFORMANT John F. Folkert		Address 107 Lampport Rd., Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - lung - right DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 163 x			INTERVAL BETWEEN ONSET AND DEATH 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July , 19 67 , to December 15 , 19 67 , that (I) (we) last saw the deceased alive on December 15 , 19 67 , and that death occurred at 8:05 A.M. from causes and on the date stated above.			
22a. SIGNATURE Clarence E. McWilliams		22b. DATE SIGNED 12-17-67	
22c. PHYSICIAN'S NAME (Type) Clarence E. McWilliams MD		22d. ADDRESS 11904 Reisterstown Rd Reisterstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/19/67	23c. NAME OF CEMETERY OR CREMATORY Manchester Cemetery	23d. LOCATION (City or Town) (County) (State) Manchester, Carroll, Md.
24. FUNERAL DIRECTOR H.J. Eckhardt		25a. REC'D BY REGISTRAR DATE DEC 20 1967	
ADDRESS Owings Mills, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1957

STATE OF DEAN

1950s

Religious

Maryland

Religious

Religious

Religious

Religious

107 Lambert Road

107 Lambert Road

Charles

Charles

Charles

Charles

White

White

Self-employed

Grocery

Grocery

John Polk

John Polk

John P. Polk

John P. Polk

1957

1957

1957

1957

CERTIFICATE OF DEATH

16506

16514

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 3 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Caton Ridge Nursing Home		d. STREET ADDRESS 5802 Highgate Drive # 15	
3. NAME OF DECEASED (Type or print) Addella		4. DATE OF DEATH Month Dec Day 28 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1891
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Allen		14. MOTHER'S MAIDEN NAME Isabelle Boyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Lana L. Milland		5721 Highgate Drive Balto. Md. 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO (b) Influenza Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile - Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-1- , 19 66 , to 12-28- 19 67 , that (I) (we) last saw the deceased alive on 12-28- 19 67 , and that death occurred at 10 P. M, from causes and on the date stated above.			
22a. SIGNATURE Cesar Valle Caven		22b. DATE SIGNED 12/29/67	
22c. PHYSICIAN'S NAME (Type) Cesar Valle Caven		22d. ADDRESS 8629 Liberty Road Randallstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12/30/67	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City or Town) (County) (State) Pikesville Balto Md
24. FUNERAL DIRECTOR Charles Byers		25a. REC'D BY REGISTRAR 8728 Liberty Rd Randallstown	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JAN 2 1968	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1431

10500

RECEIVED IN CASH

3000 Highway Drive	2700	3000 Highway Drive	2700
2700	3000 Highway Drive	2700	3000 Highway Drive

White	White	White	White
White	White	White	White

White	White	White	White
White	White	White	White

White	White	White	White
White	White	White	White

White	White	White	White
White	White	White	White

White	White	White	White
White	White	White	White

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16515

16507

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ivy Hall Nursing Home</u>				d. STREET ADDRESS <u>2413 Northern Parkway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELSIE</u> Middle <u>M.</u> Last <u>POWKES</u>				4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 14, 1882</u>	
				9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Schrecker</u>				14. MOTHER'S MAIDEN NAME <u>Magdalena Metz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Margaret Croato - Same -</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral sclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the deceased) attended the deceased from <u>Dec. 2</u> , 19 <u>67</u> , to <u>Dec. 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 9</u> , 19 <u>67</u> , and that death occurred at <u>3:50 AM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Samuel Stern M.D.</u>						22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL STERN.</u>				22d. ADDRESS <u>1010 E Belvedere Ave</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Smithfield Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Pittsburg Penna.</u>	
24. FUNERAL DIRECTOR <u>Leonard J Ruck Inc 5305 Harford Rd</u>				25a. RECD BY REGISTRAR <u>DEC 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16516					16508				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Forest Haven Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1137 Carroll Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) FRIEDA A. FOX First Middle Last					4. DATE OF DEATH December 13, 1967 Month Day Year				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21-1902		9. AGE (In years lost birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard F. Fox					14. MOTHER'S MAIDEN NAME Gretchen Struhs				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Lennox E. Fox, 1137 Carroll Street Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Chronic Heart Syndrome INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12/6 , 19 67 to 12/13 , 19 67 ; that (I) (was) lost saw the deceased alive on 12/13 , 19 67 , and that death occurred at 12:30 PM , from causes and on the date stated above.									
22a. SIGNATURE Dr. John Shaw					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/13/67		
22c. PHYSICIAN'S NAME (Type) Dr. John Shaw					22d. ADDRESS 5800 Edmondson Avenue				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-15-1967		23c. NAME OF CEMETERY OR CREMATORY Stone Chapel Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville, Maryland			
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229					25a. REC'D BY REGISTRAR DEC 15 1967		25b. REGISTRAR'S SIGNATURE John C. Jones		

110-27-13

22 3

7/15/80 (cont.)

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1651
CERTIFICATE OF DEATH
16509

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>JEANSTOWN, Md.</i> c. LENGTH OF STAY IN b <i>54 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Baltimore County General Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore, Md.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>3014</i> d. STREET ADDRESS <i>4014 Hilton Rd. 21215</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>IDA FREEDLAND</i>		4. DATE OF DEATH Month Day Year <i>12-13 1967</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>9-8-84</i>
9. AGE (In years last birthday) <i>83 yrs.</i>	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>LITHUANIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>? RUDOLPH</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>XXXXXXXX</i> 17. INFORMANT <i>MRS. EVELYN FREEDLAND, 4725 THREE OAKS RD. #21208</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.1</i> <i>Hangover, both legs</i> DUE TO (b) <i>Arteriosclerotic peripheral Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>10-20-67</i> to <i>12-13-67</i> , that (I) (we) last saw the deceased alive on <i>12-13-67</i> , and that death occurred at <i>2:30 AM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Josue C. Laredo, M.D.</i>		22b. DATE SIGNED <i>12-13-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOSUE C. LAREDO, M.D.</i>		22d. ADDRESS <i>Baltimore County Gen. Hospital</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>12-14-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>BNAI ISRAEL</i>	23d. LOCATION (City, town or county) (State) <i>BALTIMORE, MARYLAND</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>SOL KLEVINSON & BROS., 6010 REISTERSTOWN RD.</i>		25a. REC'D BY REGISTRAR <i>DEC 18 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles J. [unclear]</i>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1951

CENTRAL AIRCRAFT

WHITE

THALE

ROBERTS

AT HOME

LITONIA

RUDOLPH

LITONIA

PROS. EVELYN FREEDLAND

1951 THREE DAYS TO 1952

Chas. & Co. Inc. 1951

1951 12-13-51

John C. L. 1951

BALTIMORE, MARYLAND

1951-12-13

BOL ALERINON & SONS, 4010 REISTERSTOWN RD.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 16518 CERTIFICATE OF DEATH 16510											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Timonium c. LENGTH OF STAY IN 1b years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 102 Washington Street					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Timonium d. STREET ADDRESS 102 Washington Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First IRA Middle L. Last FREEMAN					4. DATE OF DEATH Month DEC. Day 4 Year 1967						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 28, 1918		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Verifier				10b. KIND OF BUSINESS OR INDUSTRY Int. Mag. Service		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry H. Freeman, Sr.					14. MOTHER'S MAIDEN NAME Ida Herpel						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 212-03-5440		17. INFORMANT Mrs. Evelyn C. Freeman, Same as # 2			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial Infarction, Acute. DUE TO Arteriosclerotic Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH Sudden	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 12-9-67 to 9-14-67 , that (I) was last saw the deceased alive on 9-14-67 , and that death occurred at HOME from the causes and on the date stated above.											
22a. SIGNATURE Evelyn C. Freeman					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) RUDEN S. SEBASTIAN					22d. ADDRESS 2314 E. JOPPA ROAD, BALTO. MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec. 7, 1967		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery, Baltimore, Md.			23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204					25a. REC'D BY REGISTRAR DEC 7 1967 25b. REGISTRAR'S SIGNATURE Charles Judge						

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16519

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16511

1. DECEASED-NAME (Type or Print) JOSEPH HOWARD FRENCH			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 12-31 1967			2b. HOUR 8:29 PM		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MAY 25 1911	6. AGE (in years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month 12 Day 31 Year 1967		
7a. BIRTHPLACE (State or foreign country) BALTO MD.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE		
10. CITY OR TOWN OF DEATH BALTO. Co.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST JOSEPH HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) WESTERN ELECT.		12b. KIND OF BUSINESS OR INDUSTRY RETIRED	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4309 BELMAR AVE.								
14. FATHER'S NAME First John Middle EARL Last FRENCH			15. MOTHER'S MAIDEN NAME First MARY Middle AGNES Last SELMA MYERS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO			16b. SOCIAL SECURITY NO. 21218 1890			17. INFORMANT MARGARET HELEN FRENCH ADDRESS 4309 BELMAR AVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart DUE TO, OR AS A CONSEQUENCE OF (c) Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 2+ yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County
								State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Charles F. O'Donnell		EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
				ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 1/2/68		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-1-68		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM		23d. LOCATION (City or Town) (County) (State) BELAIR Rd BALTO. Md.		
24. FUNERAL DIRECTOR THE DIPPEL BROTHERS INC 7110 BELAIR Rd				ADDRESS		25a. REC'D BY REGISTRAR JAN 3 1968		25b. REGISTRAR'S SIGNATURE Charles F. O'Donnell

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

16520

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16512

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 46 DAYS		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		d. STREET ADDRESS 15 RIVERVIEW	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MUNFORD WILLIAM A. FRENCH				4. DATE OF DEATH Month Day Year DECEMBER 15, 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 25 07		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) W. ANNAPOLIS, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM FRENCH COGGISHELL				14. MOTHER'S MAIDEN NAME EDITH M. MUNFORD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-11		16. SOCIAL SECURITY NO. 214 05 0454		17. INFORMANT Address CLIN. REC., VAH, FORT HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BLEEDING PULMONARY (OPERATIVE) ARTERY 163 X DUE TO Conditions, if any, which gave rise to immediate cause (b) WIDE SPREAD CARCINOMA OF THE LUNG, WITH ABSCESS (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>Theodore C. Patterson</i> M.D. EXAMINER'S NAME (Type) THEODORE C. PATTERSON, M.D. Address (Street, city, town, or county) DATE SIGNED 12/15/67							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Dec. 19, 1967		22c. NAME OF CEMETERY OR CREMATORY HILLCREST CEMETERY		22d. LOCATION (City, town, or county) (State) ANNAPOLIS, MARYLAND	
23. BURIAL DIRECTOR <i>Bonley E. Hopp</i> ADDRESS Hopping Funeral Home Annapolis, Maryland				24a. REC'D BY REGISTRAR DATE DEC 18 1967 24b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

MEDICAL CERTIFICATION

ANNE ARUNDEL

MARYLAND

BALTIMORE

ANNAPOLIS

45 DAYS

PORT HOWARD

15 RIVERVIEW

07

DECEMBER

FRENCH

MINOR WILLIAM A.

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WHITE

U.S.A.

W. ANNAPOLIS, MARYLAND

automobile

MECHANIC

EDITH M. MINOR

WILLIAM FRENCH COOKSHELL

2 214 05 0424 CLIN. REC., VAN, PORT HOWARD, MD.

BLEEDING PULMONARY (OPERATIVE) ARTERY

WIDE SPREAD CARCINOMA OF THE LUNG, WITH
ABSCESSES

THEODORE C. PATTERSON, M.D.

Dec. 19, 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16521 Item #8 & 9 Form #398 12/21/67 16513

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson - Rural c. LENGTH OF STAY IN 1b Towson d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 104 Dublin Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mildred		First Mildred Middle Futch Last Futch		4. DATE OF DEATH Month 12 Day 11 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1908	9. AGE (in years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore			
13. FATHER'S NAME Edward B Hopkins			14. MOTHER'S MAIDEN NAME Olive Wilcock				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No.		17. INFORMANT J.D. Futch Address 104 Dublin Rd., Towson, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170x DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 12-10 , 19 67 , to 12-11 , 19 67 , that (I) (we) last saw the deceased alive on 12-11 , 19 67 , and that death occurred at 9:45 M, from the causes and on the date stated above.					
22a. SIGNATURE John E. Adams		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/12/67			
22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.		22d. ADDRESS 6701 N. Charles Street					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-14-67		23c. NAME OF CEMETERY OR CREMATORY Greenmount			
23d. LOCATION (City, town or county) (State) Baltimore, Md.		24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.					
25a. REC'D BY REGISTRAR DEC 19 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

John E. Adams

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Pages 1, 2, and 3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16522

16514

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 14 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7322 Kirtley Road		e. STREET ADDRESS 7322 Kirtley Road	
3. NAME OF DECEASED (Type or print) First Charles Middle W. Last Gabriszeski		4. DATE OF DEATH Month December Day 16 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1919
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 16 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Logistic Engineer		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse Corp.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Gabriszeski		14. MOTHER'S MAIDEN NAME Josephine Barkiewicz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Army WWII		16. SOCIAL SECURITY NO. 187-05-7601	
17. INFORMANT (Name) Mrs. Rita Gabriszeski		Address Dundalk, Md. 7322 Kirtley Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO HCUV Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 0 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Theodore C. Patterson M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 105 Main Street	
EXAMINER'S NAME (Type) Theodore C. Patterson M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Dundalk,	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Md. 12/16/67	
		Address (Street, city, town, or county) 21222	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/20/67	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR DEC 20 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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16523

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16515

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 03	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1107 Hampton Garth		d. STREET ADDRESS 1107 Hampton Garth	
3. NAME OF DECEASED (Type or print) First MILDRED Middle STONER Last GARMAN		4. DATE OF DEATH Month DECEMBER Day 3 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1898
9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (County & State, or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Arthur Stoner	
14. MOTHER'S MAIDEN NAME Edna Weaver		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Walter E. Garman, Sr. Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized atherosclerosis & Diabetes			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959 to 12-3 , 19 67 , that (I) (we) last saw the deceased alive on 12-2 19 67 , and that death occurred at 4 P M, from causes and on the date stated above.			
22a. SIGNATURE Franklin E. Leslie		22b. DATE SIGNED 12/4/67	
22c. PHYSICIAN'S NAME (Type) Dr. Franklin Leslie		22d. ADDRESS 302 E. 33rd. St. Baltimore	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-7-67	
23c. NAME OF CEMETERY OR CREMATORY Evergreen		23d. LOCATION (City or Town) (County) (State) Gettysburg, Penna.	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212		25a. REC'D BY REGISTRAR DATE DEC 7 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1892

1891

Baltimore

Maryland

Baltimore

Town

Town

1107 Madison Street

1107 Madison Street

MILTON STOKES CARROLL

Nov. 30, 1892

Female White

Pennsylvania

National

Teacher

and Son

Arthur Stoker

White, G. W. St. 1892

St.

302 E. 33rd St. Baltimore

Dr. Franklin Leslie

Gettysburg, Penna.

Exposition

12-7-92

Bureau

600 York St. Baltimore, Md. 21212

DEC 7 1892

16524

CERTIFICATE OF DEATH

16516

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Baltimore</u> <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>		c. LENGTH OF STAY IN lb <u>87 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>Linthicum Hgts.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u>				d. STREET ADDRESS <u>410 Vance Ave 21640</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>S</u> Last <u>Meiman</u>				4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>May 19-1880</u>		9. AGE (In years lost birthday) <u>87</u> yrs.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (County & State, or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Meiman</u>				14. MOTHER'S MAIDEN NAME <u>unk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Nursing Home chart - Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>unk</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>40 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/29</u> , 19 <u>67</u> , to <u>12/23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> , 19 <u>67</u> , and that death occurred at <u>4:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>David E. Lick</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DAVID E. LICK</u>				22d. ADDRESS <u>4 VFW Lane, Ellicott City, Md 21043</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		23d. LOCATION (City or Town) (County) (State) <u>Greenmount Land Co</u>	
24. FUNERAL DIRECTOR <u>Paul E. Schenck</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

1851

1851

Wm. H. H. H.

Wm. H. H. H.

Wm. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16525

16517

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6mths. 10dys.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederick Middle John Last Geisberger		4. DATE OF DEATH Month December Day 11 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1907
9. AGE (In years lost birthday) yrs. 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Geisberger		14. MOTHER'S MAIDEN NAME Margaret	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or dates of service) Yes 1941-1942 U.S. Army		16. SOCIAL SECURITY NO. 220-03-7058	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, origin undetermined, histo- DUE TO pathology unknown, proven at Johns Hopkins (b) Hospital in about 1965, with generalized DUE TO metastases (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cellulitis with trophic ulcers 2 to 1 myphedema 2 to (a) above		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from May 31 , 1967, to Dec. 11 , 1967, that (1) (we) last saw the deceased alive on Dec. 11 , 1967, and that death occurred at 7:30 P. , from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED 12-12-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/15/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemeter.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Wm. J. Pickens Sons North		25a. REC'D BY REGISTRAR DEC 18 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

1951

CRIMINAL RECORD

1052

NAME: [illegible]

DATE: [illegible]

ADDRESS: [illegible]

STATE: [illegible]

DATE OF BIRTH: [illegible]

EDUCATION: [illegible]

SEX: [illegible]

RACE: [illegible]

HEIGHT: [illegible]

WEIGHT: [illegible]

HAIR: [illegible]

EYES: [illegible]

3-10-51

1052

REMARKS: [illegible]

DATE OF ARREST: [illegible]

CHARGE: [illegible]

12-12-51

1052

1 / 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16526						16518					
1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE					
Baltimore						Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
Baltimore						Parkville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
Greater Baltimore Medical Center						3000 Lavender Avenue					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last MARY CATHERINE GESSWEIN						Month Day Year December 5, 19 67					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7-10-1888		79 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housewife				Housewife		Baltimore, Md.			U.S.A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
William Kelly						Carrie Stahle					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				220-32-3551		Forrest Gesswein		9514 Powderhorn Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Renal Failure And Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>11/22</u> , 19 <u>67</u> , to <u>12/5</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>12/5/</u> 19 <u>67</u> , and that death occurred at <u>1:55M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>John E. Adams</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/5/67			
22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.						22d. ADDRESS Greater Baltimore Medical Center					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial				12-9-1967		Moreland Cemetery		Baltimore Co. Md.			
24. FUNERAL DIRECTOR <u>LaSalle Funeral Home</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10018

10018

John S. Adams

10018

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VR A15 (4)
25M 1/67

16527		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		16519	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrison</i>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>90 Foxleigh Nursing Home</i>			d. STREET ADDRESS <i>921 Southerly Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Annie</i> First Middle Last <i>Gillett</i>			4. DATE OF DEATH <i>December 27, 1967</i> Month Day Year		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 10, 1879</i>	9. AGE (In years and birth day) <i>88</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>England</i>	
13. FATHER'S NAME <i>Thomas Harker</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Family records</i> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Senility</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Hypertensive cardio vascular disease</i> DUE TO (c) <i></i>					INTERVAL BETWEEN ONSET AND DEATH <i>years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>1964</i> to <i>12/27</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>12/27</i> 19 <i>67</i> , and that death occurred at <i>7:55 PM</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>Mr. F. Cox</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/27/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. A. Cox 3rd</i>		22d. ADDRESS <i>1118 St. Paul St., Balto., Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Dec. 30, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rolling Green Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Camp Hill, Penna.</i>		
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>			25a. REC'D BY REGISTRAR <i>JAN 3 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Frank J. J...</i>

18213

RECEIVED OF STATE

1052



16528

CERTIFICATE OF DEATH

16520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 45 Delrey Ave.		d. STREET ADDRESS 45 Delrey Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George H. Gillman, Jr.		First Middle Last George H. Gillman, Jr.		4. DATE OF DEATH Month Day Year Dec. 11 1967	
5. SEX M	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/78	9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Howard M. Gillman		14. MOTHER'S MAIDEN NAME Emily E. Magnes		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-03-2646 A		17. INFORMANT Geo. H. Gillman, Jr. 45 Delrey Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 433.0 Cardiac Arrest IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Arterio sclerotic Cardio Vascular Disease DUE TO (c) Disease					INTERVAL BETWEEN ONSET AND DEATH Sudden ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/16 , 19 59 , to 12/11 , 19 67 , that (I) (we) last saw the deceased alive on 12/9 , 19 67 , and that death occurred at 10 A.M. from causes and on the date stated above					
22a. SIGNATURE Joseph S. Blum		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Joseph S. Blum		22d. ADDRESS 1115 N. Calvert St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/14/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Av.		ADDRESS		25a. REC'D BY REGISTRAR DEC 14 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

1482

1896

UNITED STATES

DEPARTMENT OF THE INTERIOR

GEOLOGICAL SURVEY

Section 14
T. 14 N. R. 14 E. S. 14
T. 14 N. R. 14 E. S. 14



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16529 CERTIFICATE OF DEATH 16521											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <i>Towson</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Towson</i> c. LENGTH OF STAY IN 1b <i>app. 14 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greater Balto Medical Center</i>					2. USUAL RESIDENCE (Where deceased lived, if Institution Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Howard</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i> 13-2 d. STREET ADDRESS <i>525 Old Frederick Rd</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Robert Swings Glascock</i>			4. DATE OF DEATH Month <i>Dec.</i> Day <i>22</i> Year <i>1967</i>		5. SEX <i>M</i>						
6. COLOR OR RACE <i>CAU</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-19-23</i>		9. AGE (In years last birthday) <i>44</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>C. & P. Telephone Co.</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Tel. Co.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <i>William E. Glascock</i>					14. MOTHER'S MAIDEN NAME <i>Day Margaret A. Day</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>			16. SOCIAL SECURITY NO. <i>1942-1943 216-14-2603</i>		17. INFORMANT <i>Pt. Chert</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>163X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Complication of lung</i> DUE TO (c) <i>metastasis to brain</i>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____ and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE <i>[Signature]</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>12-22/67</i>				
22c. PHYSICIAN'S NAME (Type) <i>E. LARRIVA</i>					22d. ADDRESS <i>BMC</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Dec 26, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Balto. National Cemt.</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>				
24. FUNERAL DIRECTOR <i>STERLING FUNERAL ESTATE</i>					ADDRESS <i>736 Edm. Av. Catonsville</i>		25a. RECEIVED BY REGISTRAR <i>DEC 27 1967</i>				
					25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

1953

Director of
Revenue of
British Columbia

[Signature]
Director

ENC 1
15-55/57

CERTIFICATE OF DEATH

16522

16530

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN lb 15 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		e. STREET ADDRESS Box 207	
3. NAME OF DECEASED (Type or print) First Middle Last Sally Ann GODEY		4. DATE OF DEATH Month 12 Day 31 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/26/43
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Rasin Godey		14. MOTHER'S MAIDEN NAME Patricia Rose Frances Roseberry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no --		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Necrotizing bronchial pneumonia DUE TO (b) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Inst. Lateralized, Mongolism, 15 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 1/10 , 19 52 , to 12/31 , 19 67 , that (X) (we) last saw the deceased alive on 12/31 , 19 67 , and that death occurred at 11:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE Richard A. Jones		22b. DATE SIGNED 1/2/68	
22c. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.		22d. ADDRESS Rosewood St. Hosp., Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/5/68	
23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery		23d. LOCATION (City or Town) (County) (State) Owings Mills, Md.	
24. FUNERAL DIRECTOR J. F. Eline & Sons		25a. REC'D BY REGISTRAR Reisters own, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JAN 9 1968	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10000

RECEIVED OF DEATH

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16531

CERTIFICATE OF DEATH

16523

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Baltimore - RANDALLSTOWN</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>_____</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN lb <u>32 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u>		d. STREET ADDRESS <u>3631 W. Belvedere Ave.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>S.</u> Last <u>Goldman</u>		4. DATE OF DEATH Month <u>12</u> - Day <u>2</u> Year <u>19 67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <u>Clauqueur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi Cab</u>	9. AGE (In years last birthday) <u>67</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Israel Goldman</u>		14. MOTHER'S MARDEN NAME <u>Sarah Goldman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-07-6604A</u>	
17. INFORMANT <u>Mrs. Martin Goldman</u>		Address <u>3419 Jonellen Dr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Carcinoma of the rectum with</u> stating the underlying cause lost. (c) <u>metastases.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-1-67</u> , 19 <u>67</u> , to <u>12-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-1</u> , 19 <u>67</u> , and that death occurred at <u>12:20</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Wenifredo N. Iglesia</u>		22b. DATE SIGNED <u>12-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. WENIFREDO N. IGLESIA</u>		22d. ADDRESS <u>BALTIMORE COUNTY GENERAL HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Providence St. Elizabeth's Assn. Balto. Md.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Sal. Liverson Bros.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 5 1967</u>	

10033

ORIGINAL OF DATA

10033

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
ISM 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16532 CERTIFICATE OF DEATH 16524											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN MD. yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 69 Burke Ave						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 69 Burke Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Lulu Todd Gore						4. DATE OF DEATH 12-24-1967 Month 12 Day 24 Year 1967					
5. SEX F		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 18, 1882		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 7 Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Dorchester Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Goldsmith Todd						14. MOTHER'S MAIDEN NAME Mary Jones					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 218-50-6263		17. INFORMANT Elsie G. Gore, 69 Burke Ave. Towson, Md. 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OCCLUSION OF CORONARY ARTERY 4201 DUE TO ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov 4 , 19 67 to Dec. 24 , 19 67 , that (I) (we) last saw the deceased alive on Dec 1 , 19 67 , and that death occurred at 11:40 A.M. from the causes and on the date stated above.											
22a. SIGNATURE A.S. Choyant M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec 24, 67			
22c. PHYSICIAN'S NAME (Type) Dr. A.S. Choyant						22d. ADDRESS 6210 YORK ROAD, BALTIMORE, MD 21222					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-27-1967		23c. NAME OF CEMETERY OR CREMATORY Parkwood				23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24 FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Brooks Towson, Md.						25a. REC'D BY REGISTRAR DEC 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

1833A

CERTIFICATE OF DEATH

1833

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)
6M 1/67

16533

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16525

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore rural</u>		c. LENGTH OF STAY IN 1b <u>45 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - rural - over</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10 East Elm Ave</u>				d. STREET ADDRESS <u>10 East Elm Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PAUL TALBOT GOUSHA</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Aug 1893</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrician</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Gausa</u>				14. MOTHER'S MAIDEN NAME <u>Dena Hartman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Emma Gousha 10 East Elm Avenue</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4221</u> IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Undet</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John C. Hyle</u> M.D.				22. DATE SIGNED <u>12-22-67</u>			
EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>7527 Belton Rd</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-27-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Loasohn Funeral Home 7401 Belton Road</u>				25a. RECEIVED BY REGISTRAR <u>DEC 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10228

THEYLAND PHOTO

10228

12 ft. of stone masonry

10 ft. of stone masonry

10 ft. of stone masonry

10 ft. of stone masonry

10 ft. of stone masonry

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16534

16526

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6yr9mths	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 419 West Gate Road	
3. NAME OF DECEASED (Type or print) Christine Alberta Grace		4. DATE OF DEATH Month December Day 5 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1907
9. AGE (In years lost birthday) 60 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stenographer		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME GRACE (DECEASED)		14. MOTHER'S MAIDEN NAME UNKNOWN (DECEASED)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give year or dates of service) _____		16. SOCIAL SECURITY NO. 216-18-3859	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9037 Massive pulmonary embolism		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of ischium - three weeks		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell to the floor	
20c. TIME OF INJURY Month, Day, Year 11-22-67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Spring Grove Hospital	
21. I certify that (this hospital) attended the deceased from Feb. 27, 1959 to Dec. 5, 1967 , that (we) last saw the deceased alive on Dec. 5, 1967 , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Edward F. Wilson		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) Edward F. Wilson, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/7/67	23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR WEBER FUNERAL HOME 5311 EDWARDS AVE.		25a. REC'D BY REGISTRAR DEC 7 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16535

16528

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> ✓ b. COUNTY <u>304</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>119 days</u>		d. STREET ADDRESS <u>601 Collett Street 21217</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>SIDNEY</u> Last <u>GREEN</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>26</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1901</u>
9. AGE (In years last birthday) yrs. <u>66</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Race Track</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Green</u>	
14. MOTHER'S MAIDEN NAME <u>Matilda Brooks</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW-11</u>	
16. SOCIAL SECURITY NO. <u>218 07 58 48</u>		17. INFORMANT <u>Clinical Rcds, VA Hospital, Fort Howard, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ARTERIOSCLEROTIC CORONARY THROMBOSIS</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL ARTERIOSCLEROSIS WITH MULTIPLE THROMBOSES AND HEMIPARESIS,</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18b) <u>BILATERAL.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Aug. 29, 19 67</u> to <u>Dec. 26, 19 67</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Dec. 26, 19 67</u> , and that death occurred at <u>11:30</u> from causes and on the date stated above.			
22a. SIGNATURE <u>J. D. Talbert</u>		22b. DATE SIGNED <u>12/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. TALBERT, M.D.</u>		22d. ADDRESS <u>VA Hospital, Fort Howard, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Arbutus, Maryland</u>
24. FUNERAL DIRECTOR <u>GEORGE KELSON FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>1348 N Calhoun St. Balto. Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>DEC 27 1967</u>		25c. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1855

COGNATE OF DEATH

1855



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16536						CERTIFICATE OF DEATH			16529		
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u>				c. LENGTH OF STAY IN 1b <u>14 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Villa Maria, Notch Cliff</u>						d. STREET ADDRESS <u>Glen Arm Rd,</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>St. Mary Laurina Greenfeld</u>						4. DATE OF DEATH <u>12</u> Month <u>9</u> Day <u>19</u> Year <u>67</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-12-1879</u>		9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 Year Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hudson City New Jersey</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Herman Greenfeld</u>						14. MOTHER'S MAIDEN NAME <u>Frances Kumber</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-54-3001</u>		17. INFORMANT <u>St. M. Kathleen</u>		Address <u>Glen Arm Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u> </u> (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>					
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>66</u> , to <u>November</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>August</u> 19 <u>67</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>Henry McCorkle</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-13-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Henry McCorkle MD</u>						22d. ADDRESS <u>Phoenix, Md 21131</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Dec 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SISTERS CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>GLEN ARM, MARYLAND</u>					
24. FUNERAL DIRECTOR <u>Raymond J. Curran</u>						ADDRESS <u>317 S. CARLETON DR</u>		25b. REGISTERAR'S SIGNATURE <u>James J. Judge</u>		DATE <u>DEC 26 1967</u>	

10333

DEPARTMENT OF STATE

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RECEIVED
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

16537		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		16530			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Randallstown</u>		c. LENGTH OF STAY IN lb <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Randallstown</u> 03-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10196 Steffeny Road</u>				d. STREET ADDRESS <u>10916 Steffeny Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Walter A. Gries</u>				4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 29, 1898</u> 68 yrs.			
9. AGE (In years last birthday) <u>68</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Arnold J. Gries</u>		14. MOTHER'S MAIDEN NAME <u>Mary Triplett</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mrs. Frances Gries</u> Address <u>Randallstown Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Coronary insuff.</u> DUE TO (c) <u>HASCVD.</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>April</u> , 19 <u>63</u> to <u>Dec 1</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>Dec 1</u> , 19 <u>67</u> , and that death occurred at <u>4:02</u> M, from causes and on the date stated above.									
22a. SIGNATURE <u>John J. Darrell</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-5-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. Darrell</u>				22d. ADDRESS <u>9017 Liberty Rd Randallstown</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-7-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wards Chapel Cemetery Balto Co Md.</u>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <u>Harry W. Knight</u> <u>Sykesville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16538

CERTIFICATE OF DEATH

16531

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 30 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 1117 Harlem Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEONARD First Middle Last ----- GRIFFIN		4. DATE OF DEATH Dec. 28 Month Day Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/5/89
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Meat House	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Samuel Griffin		14. MOTHER'S MAIDEN NAME Mamie Griffin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 214 03 11 96	
17. INFORMANT Clinical Rcds, VA Hospital, Fort Howard Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFARCTION OF MYOCARDIUM 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Recent			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ABSCESS, RIGHT LUNG			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) <input checked="" type="checkbox"/> this hospital attended the deceased from Nov. 28 , 19 67 to Dec. 28 , 19 67 , that (2) <input checked="" type="checkbox"/> we lost the deceased alive on Dec. 28 , 19 67 , and that death occurred at 9:20 M, from causes and on the date stated above.			
22a. SIGNATURE J. D. Talbert		22b. DATE SIGNED 12/29/67	
22c. PHYSICIAN'S NAME (Type) J. D. TALBERT, M.D.		22d. ADDRESS VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-2-68	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR ELROY WILSON FUNERAL HOME		25a. REC'D BY REGISTRAR DATE	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

JAN 2 1968

1853

ESTIMATE OF DEATH

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REPORT

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16539

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16532

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		e. STREET ADDRESS -	
3. NAME OF DECEASED (Type or print) First Vera Middle Bernice Last GRIFFITH		4. DATE OF DEATH Month 12 Day 6 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 46 yrs.
13. FATHER'S NAME Robert Carl Griffith (D)		14. MOTHER'S MAIDEN NAME Hattie Louise Brooks (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service no --		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis and Pneumonia, Right DUE TO Empyema, Right (b) Pulmonary Laceration, Superficial DUE TO Fracture ribs 4,5,&6 Right (c) estimated		INTERVAL BETWEEN ONSET AND DEATH 7-10 days 7-10 days 7-10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mental Retardation due to traumatic encephalopathy estimated 46 yrs.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) unknown	
20c. TIME OF INJURY Month, Day, Year Hour a.m. unknown p.m. unknown		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Rosewood		20f. (City or town) (County) (State) Owings Mills - Balt. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) Reisterstown, Md.	
23a. BURIAL (CREMATION, REMOVAL) (Specify) Burial		23b. DATE THEREOF 12-9-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Harmony Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Owings Calvert Md.	
24. FUNERAL DIRECTOR Hutchins Funeral Home Owings, Md.		25a. REC'D BY REGISTRAR DEC 12 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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MINERAL EXPLORATION

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

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16540

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16533

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roxson Parkville		c. LENGTH OF STAY IN lb Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1705 Taylor Avenue		d. STREET ADDRESS 1705 Taylor Avenue	
3. NAME OF DECEASED (Type or print) First DONALD Middle MICHAEL Last GRIM		4. DATE OF DEATH December 28, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1967.
9. AGE (In years last birthday) yrs. 5		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas S. Grim		14. MOTHER'S MAIDEN NAME Reeda Haman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Thomas S. Grim		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitital/ pneumonia/ (SDI) DUE TO (b) Early bronchopneumonia (SDII) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		M.D.	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED December 28, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/67.	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE JAN 2 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

16541		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		16534	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2933 Willoughby Road			d. STREET ADDRESS 2933 Willoughby Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ellen Brady Groves			4. DATE OF DEATH 12/17/67 19 67		
5. SEX f	6. COLOR OR RACE w	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/1882	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME unknown Brady			14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT daughter Address 2933 Willoughby Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Atherosclerosis - Hypertensive DUE TO C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/1/67 , 19 67 , to 12/17 , 19 67 , that (I) (we) last saw the deceased alive on 12/17 19 67 , and that death occurred at 9:55 A.M. from causes on and on the date stated above.					
22a. SIGNATURE Nathan Janney		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/18/67	
22c. PHYSICIAN'S NAME (Type) Dr. Nathan Janney		22d. ADDRESS 7101 Harford Road			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12/21/67		23c. NAME OF CEMETERY OR CREMATORY Parkwood	
24. FUNERAL DIRECTOR CHAS. F. EVANS & SON		ADDRESS 8802 Harford Road		25a. REC'D BY REGISTRAR DEC 22 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

1958

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Baltimore County
Marvyn

2033 Wilton Road
Clenbury Road
19117

10/1/88

at home
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daughter
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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16542

16535

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Riderwood	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 7906 Roldrew Avenue	
3. NAME OF DECEASED (Type or print) First CONSTANCE Middle C Last GUNTHER		4. DATE OF DEATH Month December Day 21 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 19, 1920
9. AGE (In years lost birthday) yrs. 47		10. IF UNDER 1 YEAR Months 03 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leroy P. Collins		14. MOTHER'S MAIDEN NAME Constance J. Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wm. E. Gunther		Address Cockeysville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute ethylism			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver in auto-auto collision	
20c. TIME OF INJURY Hour 9:06 p.m. Month, Day, Year 12-21 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	20f. (City or town) (County) (State) Towson Baltimore Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		22. DATE SIGNED December 22, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/1967	
23c. NAME OF CEMETERY OR CREMATORY St. Luke, S Cemetery		23d. LOCATION (City or Town) (County) (State) Fine Creek Mills, Va.	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Rd Towson, Md		25a. REC'D BY REGISTRAR DEC 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16543

16536

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>B. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN lb <u>12-15-67-12-20 3229 Dundalk Ave-DUNDALK MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>3729 DUNDALK AVE 03-1</u>	
3. NAME OF DECEASED (Type or print) <u>William Howard Hackett</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-98</u>
9. AGE (In years lost birthday) yrs. <u>69</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Hackett (DEC)</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET BARTHEL</u> <u>unk at time of Adm.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-9880</u>	
17. INFORMANT <u>MARY E. HACKETT 3729 DUNDALK AV</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis right middle cerebral artery</u> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 15th</u> , 1967, to <u>Dec. 20th</u> , 1967, that (I) (we) last saw the deceased alive on <u>Dec. 20th</u> , 1967, and that death occurred at <u>4:10 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Gabrielle Marie Gregor</u>		22b. DATE SIGNED <u>Dec. 20th 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE ROVETI</u>		22d. ADDRESS <u>6701 N. Charles St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>	23d. LOCATION (City or Town) (County) (State) <u>COLGATE MD</u>
24. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME - DUNDALK MD</u>		25a. REC'D BY REGISTRAR <u>DEC 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			

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STATE OF DEAN

Baltimore

Maryland

B. 10

Baltimore
Greater Baltimore Medical Center

12-12-1852-2432

William

Hackett

Dec

Male can

4-12-18 18

Retired

Maryland

James Hackett (Dec)

Wk at time of adm.

11-10-1852

16544

CERTIFICATE OF DEATH

16537

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xxxXXXXXX Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xxxxxxx, Md. CATONSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore Co. Gen. Hosp.		d. STREET ADDRESS 5454 Addington Road xxxxxxx	
3. NAME OF DECEASED (Type or print) First Middle Last xxxx Frances B. Hall		4. DATE OF DEATH Month Day Year 12. 27 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/78 AGE (In years birthday) 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME John A. Graves		14. MOTHER'S MAIDEN NAME Mary Owens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 9040 DUE TO (b) Fracture Hip, Left DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Nov 9 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) Balto Md
21. I certify that (I) (this hospital) attended the deceased from Nov. 28, 1967 , to Dec. 27, 1967 , that (I) (we) last saw the deceased alive on 12-27 1967 , and that death occurred at 11:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Jose C. Laredo M.D.		22b. DATE SIGNED 12-27-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/30/67	23c. NAME OF CEMETERY OR CREMATORY Holy Cross	23d. LOCATION (City or Town) (County) (State) Anne Arundel Co. Md.
24. FUNERAL DIRECTOR McCully Funeral Home		25a. REC'D BY REGISTRAR DATE JAN 2 1968	
ADDRESS 237 Patapsco Ave.		25b. REGISTRAR'S SIGNATURE Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1883

DEPARTMENT OF JUSTICE

1883

RECEIVED

RECEIVED

AMERICAN SAVING CO. NO.

1883

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1966

CERTIFICATE OF DEATH

16545

16538

1. PLACE OF DEATH a. COUNTY <u>Balta.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>MD</u> b. COUNTY <u>Balta.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balta</u>		c. LENGTH OF STAY IN lb <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balta</u> - 28		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u>			d. STREET ADDRESS <u>125 Winters Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Helen A. Hall</u>			4. DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>1967</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>3-30-07</u>		9. AGE (In years last birthday) Yrs. <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>Daniel H. Hriday</u>			14. MOTHER'S MAIDEN NAME <u>Jennie W. Williams</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Nursing Home Chart</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis</u> DUE TO <u></u> (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Prior Strokes</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>67</u> , to <u>12/11</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>12/11</u> 19 <u>67</u> and that death occurred at <u>4:20 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>David E. Zickel</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>David E. Zickel</u>		22d. ADDRESS <u>4 VFW where, Ellicott City, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-15-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>	
23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR ADDRESS <u>Arlington S. Phillips 1727 N. Monroe Street</u>			
25a. REC'D BY REGISTRAR DATE <u>DEC 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
16546													
16539													
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge - 21212							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 249 A Rodgers Forge Rd.-21212						d. STREET ADDRESS 249 A Rodgers Forge Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle BERTRAM Last HANAUER, Jr.						4. DATE OF DEATH Month December Day 8, Year 19 67							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1892		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROGRAM DIRECTOR RADIO STATION, RETIRED				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A				
13. FATHER'S NAME William Bertram Hanauer						14. MOTHER'S MAIDEN NAME Emma M. Seidler							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War I						16. SOCIAL SECURITY NO. 212-09-2751A						17. INFORMANT Address Mrs. Beth T. Hanauer-249 A Rodgers Forge Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crownary Insufficiency													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic H. D.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic H. D. Embolus													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19													
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>													
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)													
20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from 1950 to 12/8 , 19 67 , that (I) (we) last saw the deceased alive on 11/15 , 19 67 , and that death occurred at 11 A.M. from the causes and on the date stated above.													
22a. SIGNATURE C. Edward Leach						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) C. EDWARD LEACH						22d. ADDRESS 14 E. Eager St. - 12-9-67							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation Dec. 9, 1967				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory				23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE H. Sander & Sons, Inc. Balto., Md.						25a. REC'D BY REGISTRAR DEC 12 1967						25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>1</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> <div>11</div> <div>12</div> <div>13</div> <div>14</div> <div>15</div> <div>16</div> <div>17</div> <div>18</div> <div>19</div> <div>20</div> <div>21</div> <div>22</div> <div>23</div> <div>24</div> <div>25</div> <div>26</div> <div>27</div> <div>28</div> <div>29</div> <div>30</div> <div>31</div> <div>32</div> <div>33</div> <div>34</div> <div>35</div> <div>36</div> <div>37</div> <div>38</div> <div>39</div> <div>40</div> <div>41</div> <div>42</div> <div>43</div> <div>44</div> <div>45</div> <div>46</div> <div>47</div> <div>48</div> <div>49</div> <div>50</div> <div>51</div> <div>52</div> <div>53</div> <div>54</div> <div>55</div> <div>56</div> <div>57</div> <div>58</div> <div>59</div> <div>60</div> <div>61</div> <div>62</div> <div>63</div> <div>64</div> <div>65</div> <div>66</div> <div>67</div> <div>68</div> <div>69</div> <div>70</div> <div>71</div> <div>72</div> <div>73</div> <div>74</div> <div>75</div> <div>76</div> <div>77</div> <div>78</div> <div>79</div> <div>80</div> <div>81</div> <div>82</div> <div>83</div> <div>84</div> <div>85</div> <div>86</div> <div>87</div> <div>88</div> <div>89</div> <div>90</div> <div>91</div> <div>92</div> <div>93</div> <div>94</div> <div>95</div> <div>96</div> <div>97</div> <div>98</div> <div>99</div> <div>100</div>											
<div>16547</div> <div>16540</div>											
<div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Baltimore</div> <div>MD</div>						<div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE</div> <div>Maryland</div> <div>b. COUNTY</div> <div>Baltimore</div>					
<div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Towson</div>						<div>c. LENGTH OF STAY IN 1b</div> <div>18 days</div>					
<div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Baltimore, Maryland</div>						<div>d. STREET ADDRESS</div> <div>2728 Miles Ave</div>					
<div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Greater Baltimore Medical Center</div>											
<div>3. NAME OF DECEASED (Type or print)</div> <div>Marie S. Harrington</div>											
<div>4. DATE OF DEATH</div> <div>12 3 1967</div>											
<div>5. SEX</div> <div>F</div>											
<div>6. COLOR OR RACE</div> <div>W</div>											
<div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>											
<div>8. DATE OF BIRTH</div> <div>4-3-12</div>											
<div>9. AGE (in years last birthday)</div> <div>55 yrs.</div>											
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Housewife</div>											
<div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div></div>											
<div>11. BIRTHPLACE (County & State, or foreign country)</div> <div>Virginia</div>											
<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.</div>											
<div>13. FATHER'S NAME</div> <div>Henry L. Looker</div>											
<div>14. MOTHER'S MAIDEN NAME</div> <div>Rogers, Nannie S.</div>											
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)</div> <div>NA</div>											
<div>16. SOCIAL SECURITY NO. (If yes give war or dates of service)</div> <div>579-07-5829</div>											
<div>17. INFORMANT</div> <div>G BMC Admission Sheet</div>											
<div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) Carcinoma of the bladder c multiple</div> <div>1810</div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</div> <div>DUE TO (b) Pulmonary + bony metastases</div> <div>DUE TO (c)</div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>											
<div>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div>											
<div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</div>											
<div>20c. TIME OF INJURY Month, Day, Year</div> <div>Hour a.m. p.m.</div> <div>19</div>											
<div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div>											
<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div>											
<div>20f. (City or town) (County) (State)</div>											
<div>21. I certify that (I) (this hospital) attended the deceased from 11-15, 1962, to 12-3, 1962, that (I) (we) last saw the deceased alive on 12-3, 1962, and that death occurred at 5:45 PM, from the causes and on the date stated above.</div>											
<div>22a. SIGNATURE</div> <div>Durgadas Kulkarni</div>											
<div>22b. DATE SIGNED</div> <div>12-3-67</div>											
<div>22c. PHYSICIAN'S NAME (Type)</div> <div>DURGADAS KULKARNI</div>											
<div>22d. ADDRESS</div> <div>G BMC Balto 4 MD.</div>											
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>											
<div>23b. DATE THEREOF</div> <div>12/5/1967</div>											
<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Holly Hill Cemetery</div>											
<div>23d. LOCATION (City, town or county) (State)</div> <div>Baltimore, Md.</div>											
<div>24. FUNERAL DIRECTOR</div> <div>Address</div> <div>Eugenia K. Seitz 5209 York Rd.</div> <div>Seitz Funeral Home Balto. Md. 21212</div>											
<div>25a. REC'D BY REGISTRAR</div> <div>DATE DEC 5 1967</div>											
<div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>											

Can increase of the plant's growth be
achieved by a single treatment?

12. 3. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 8

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a temporary certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|--|--|---|---|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Owings Mills
c. LENGTH OF STAY IN 1b
2 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
11009 Reisterstown Road | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Owings Mills
d. STREET ADDRESS
11009 Reisterstown Road
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print)
Theodore Earl Harris | | | 4. DATE OF DEATH
December 16 1967 | | 5. SEX
Male | | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
May 31, 1890 | | | 9. AGE (In years last birthday)
77 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Railroad Worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Pennsylvania R.R. Baltimore Co., Md. | | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Harris | | | 14. MOTHER'S MAIDEN NAME
Troyer | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | 16. SOCIAL SECURITY NO.
716-01-8358 | | 17. INFORMANT
Mrs. Ruth Showalter | | | Address
1314 Nelson St. Richmond, Va. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
260x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Arteriosclerotic C-V Disease
DUE TO (c) Diabetes
1 yr.
4 yrs. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
none | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour e.m. none 19
p.m. | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
D. D. Caples | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22. DATE SIGNED
12-18-67 | | |
| EXAMINER'S NAME (Type)
D. D. Caples, M. D. | | | 6 Hanover Rd., Reisterstown, Md. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | Address (Street, city, town, or county) | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
12/20/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR
H. J. Eckhardt | | | ADDRESS
Owings Mills, Md. | | | 25a. REC'D BY REGISTRAR
DEC 20 1967 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

1954

1953

UNITED STATES DEPARTMENT OF AGRICULTURE

Washington

Marion

Bellevue

John A. Smith

2 months

John A. Smith

11000 Belvidere Road

11000 Belvidere Road

Theodore Earl Harris

December 1953

May 21, 1950

John A. Smith

Bellevue

Bellevue, W. R. Harris Co., Inc.

Harris

716-01-8328 Mrs. Ruth Sherrill, 1314 Nelson St., Richmond, Va.

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue



none

none

none

none

2.2 copies

U. S. Census, N. D.

U. S. Census, N. D.

12/20/57

Bellevue Cemetery

Bellevue, Maryland

John A. Smith

John A. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15
6M 1/67

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|---------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Balto 13
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto 13, Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital | | d. STREET ADDRESS 7620 York Rd. Balto. #4 MD. | |
| 3. NAME OF DECEASED (Type or print) Lillie Harrison | | 4. DATE OF DEATH 12 20 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-11-1907 |
| 9. AGE (In years lost birthday) 60 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day work | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Levin Teagle | | 14. MOTHER'S MAIDEN NAME Laura Teagle | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 260x
DUE TO Massive hemorrhage of brain
(b) Wenckebach's metathesis
DUE TO Obesity - hypertensive
(c) Obesity - hypertensive
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| INTERVAL BETWEEN ONSET AND DEATH 5+ yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II at item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
ot work ot work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell M.D. | | 22. DATE SIGNED 12/20/67 | |
| EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Dec 23/67 | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY Carroll Memorial | | 23d. LOCATION (City or Town) (County) (State) Laurel Md | |
| 24. FUNERAL DIRECTOR Miller E. Elickson | | 25a. REC'D BY REGISTRAR 1/29/68 | |
| ADDRESS 11297 K. K. Road | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| DATE DEC 29 1967 | | | |

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[Faint, illegible handwriting covering the bottom half of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 16543 | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>—</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Fort Howard</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | |
| c. LENGTH OF STAY IN lb
<u>185 days</u> | | d. STREET ADDRESS
<u>225 N. Carrollton Avenue</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Veterans Administration Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>JAMES LEON HARVEY</u> | | 4. DATE OF DEATH
Month Day Year
<u>Dec. 28 19 67</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2/13/13</u> |
| 9. AGE (In years last birthday)
<u>54</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
<u>19 67</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Store Keeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Self Employed</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Americano, Ga.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Grady Harvey</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sallie Americus</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
<u>Yes WW-II</u> | | 16. SOCIAL SECURITY NO.
<u>214 01 20 24</u> | |
| 17. INFORMANT
<u>Clinical Rcds VA Hospital, Fort Howard, Md.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARCINOMA OF RECTUM WITH METASTASIS</u>
DUE TO
154X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>—</u>
DUE TO
(c) <u>—</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>UNKNOWN</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 26, 19 67</u> , to <u>Dec. 28, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Dec. 28 19 67</u> and that death occurred at <u>8 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>George McElfatrick</u> | | 22b. DATE SIGNED
<u>12/29/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>GEORGE McELFATRICK, M.D.</u> | | 22d. ADDRESS
<u>VA Hospital, Fort Howard, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>1-2-68</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Calvary Cemetery</u>
<u>Baltimore National</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>Randolph J. Collick</u>
<u>COLLICK FUNERAL HOME</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 2 1968</u>
25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

VR A15 (4)
25M 1/67

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OFFICE OF THE

Director

7-10-1944

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16551

16544

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Baltimore
c. LENGTH OF STAY IN lb
Minutes.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Old York Road | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Virginia
b. COUNTY
?
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Virginia Beach
d. STREET ADDRESS
24 Spartin St.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Daniel C. Hawkins | | 4. DATE OF DEATH
Month 12 Day 23 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 3, 1927 |
| 9. AGE (In years lost birthday)
40 yrs. | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cabinetmaker | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
H. C. Hawkins | | 14. MOTHER'S MAIDEN NAME
Susie Saunders | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO.
WM 1945-187528361914 | |
| 17. ADDRESS
H. C. Hawkins York Rd, Monkton, Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Whiplash injury of neck
DUE TO (b) 8224
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Driver in auto that overturned | |
| 20c. TIME OF INJURY Month, Day, Year
12:45 xx 12 23 19 67 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Street | | 20f. (City or town) (County) (State)
Baltimore Baltimore, Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | 22. DATE SIGNED
12-23-67 | |
| EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Dec. 26, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Wiseburg Cemetery | | 23d. LOCATION (City or town) (County) (State)
White Hall, Md. | |
| 24. FUNERAL DIRECTOR
Isaac Hartenstein, New Freedom, Pa. | | 25a. REC'D BY REGISTRAR
DEC 29 1967 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16552

CERTIFICATE OF DEATH

16545

| | | | | | | | |
|---|--|--|---|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | c. LENGTH OF STAY IN/1b
15 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21234 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. JOSEPH HOSPITAL | | | | d. STREET ADDRESS
2615 Edgewood Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Gordon Middle Irvin Last HENSCHEN | | | | 4. DATE OF DEATH
Month December Day 19 Year 1967 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
June 21, 1926 | |
| 9. AGE (In years last birthday)
41 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Metalurgist | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Bethlehem Steel | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 13. FATHER'S NAME
IRVIN Henschel | | | | 14. MOTHER'S MAIDEN NAME
ELISE WILLS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
yes WWII | | 16. SOCIAL SECURITY NO.
219-16-4663 | | 17. INFORMANT
Catherine Henschel Address Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic brain tumor
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Hypernephroma
DUE TO
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/4/ , 19 67 , to 12/19/ , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/19/ , 19 67 , and that death occurred at 1:10 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
B. Olivos | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
12/19/67 | |
| 22c. PHYSICIAN'S NAME (Type)
B. Olivos, M.D. | | | | 22d. ADDRESS
7620 York Rd., Towson, Md., 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| BURIAL | | 12-23-67 | | Garden of Faith | | Baltimore Md | |
| 24. FUNERAL DIRECTOR
Chas. T. Evans | | | | ADDRESS
8802 Harford Rd | | 25a. REC'D BY REGISTRAR
DEC 26 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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16546

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u>
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Balti.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Balti.</u> | | c. LENGTH OF STAY IN 1b
<u>20 DAYS</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Greater Balt. Med. Center</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Barbara Catherine Hestrick</u> | | 4. DATE OF DEATH
Month <u>12</u> Day <u>28</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1-25-1903</u> |
| 9. AGE (In years last birthday)
<u>64</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Telephone Operator</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Balti. MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Louis Stallman, (Dec.)</u> | | 14. MOTHER'S MAIDEN NAME
<u>Barbara Schwenker</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>NA</u> | | 16. SOCIAL SECURITY NO.
<u>NA</u> | |
| 17. INFORMANT
<u>Admission Sheet</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>
DUE TO <u>1930</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>Brain</u>
(b) <u>Oligoblastoma multiforme</u>
DUE TO <u>3</u>
<u>months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>a.m.</u> <u>19</u> p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-9-1967</u> to <u>12-29-1967</u> , that (I) (we) last saw the deceased alive on <u>12-29-1967</u> , and that death occurred at <u>8:35 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Josefina A. de Castro</u> | | 22b. DATE SIGNED
<u>12-29-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>MA. JOSEFINA A. DE CASTRO</u> | | 22d. ADDRESS
<u>GBMC</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>1-3-1968</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore City Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Lassahn Funeral Home</u> | | 25a. REC'D BY REGISTRAR
<u>JAN 3 1968</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16554

CERTIFICATE OF DEATH

16547

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Spring Grove State Hosp | | e. STREET ADDRESS
1019 Scotts Hill Drive | |
| 3. NAME OF DECEASED (Type or print)
First Joseph Middle — Last Hettelman | | 4. DATE OF DEATH
Month 12 Day 16 Year 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
1982 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
XXXXXXXXXXXXXXXXXXXX | | 10b. KIND OF BUSINESS OR INDUSTRY
ATTORNEY — LAW | 9. AGE (In years last birthday)
85 yrs. |
| 11. BIRTHPLACE (County & State, or foreign country)
Russia | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
MOSES HETTMAN | | 14. MOTHER'S MAIDEN NAME
— | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
219-32-19541 | |
| 17. INFORMANT
MR. EUGENE HETTMAN | | Address 1015 SCOTTS HILL DR. #8 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Arteriosclerotic Cardiovascular disease —
DUE TO years
(c) — | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8 31, 1967 , to 12 16, 1967 , that (I) (we) last saw the deceased alive on 12 16, 1967 , and that death occurred at 12 10 PM , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
George A. Rodon M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
George A. Rodon M.D. | | 22d. ADDRESS
SPRING GROVE ST. HOSP. — | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12-18-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
ANSHE EMUNAH AITZ CHAIM | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD. | | 25a. REC'D BY REGISTRAR
DEC 20 1967 | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Jones | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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16555

CERTIFICATE OF DEATH

16548

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Carney</u> | | c. LENGTH OF STAY IN 1b
<u>Baltimore</u> 21234 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>3416 E. Joppa Road</u> | | d. STREET ADDRESS
<u>3416 E. Joppa Road</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Peter</u> Middle <u>N.</u> Last <u>Hiebler</u> | | 4. DATE OF DEATH
Month <u>December</u> Day <u>26</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 8, 1912</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Chauffeur</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Public Schools</u> | 9. AGE (In years last birthday)
<u>55</u> yrs. |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Phillip J. Hiebler</u> | | 14. MOTHER'S MAIDEN NAME
<u>Catherine Knox</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>215-05-8754</u> | |
| 17. INFORMANT
<u>Mrs. Camille Hiebler</u> | | Address
<u>(Same)</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>
DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 minutes</u>
<u>Several years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. _____ 19 _____ | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 19 1966</u> to <u>Dec 19 1967</u> that (I) (we) last saw the deceased alive on <u>Dec 19 1967</u> , and that death occurred at <u>4:45 P.M.</u> from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Seymour H. Rubin</u> | | 22b. DATE SIGNED
<u>12/27/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Seymour H. Rubin, M.D.</u> | | 22d. ADDRESS
<u>5415 Park Heights Blvd</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>12/30/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parkwood Cem.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Balto. Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 28 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16556

CERTIFICATE OF DEATH

16549

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
lyrllmth3dys | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
4208 White Avenue - Overlea, Md. | | d. STREET ADDRESS
4208 White Avenue | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Margaret | | 4. DATE OF DEATH
Month December Day 4 Year 19 67 | |
| 5. SEX
female | | 6. COLOR OR RACE
white | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Jan. 18, 1887 | |
| 9. AGE (In years last birthday)
80 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
home | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
William Harman | | 14. MOTHER'S MAIDEN NAME
Caroline Appold | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
219-54-3164-JI | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Cardiovascular Ht. Dis.
DUE TO
(c) Arteriosclerosis, Generalized, Senile | | INTERVAL BETWEEN ONSET AND DEATH
1 Hr.
2 yrs.
10 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Diabetes Mellitus | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 31 , 19 65 , to Dec. 4 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 4 , 19 67 , and that death occurred at 8:30 M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Anthony J. Young, M.D. | | 22b. DATE SIGNED
12-4-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Dec. 7, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Woodlawn, Maryland | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Road
Towson, Maryland 21204 | | 25a. REC'D BY REGISTRAR
DEC 7 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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|--|----------------------------------|--|--|
| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 16557 | | 16550 | |
| CERTIFICATE OF DEATH | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN ib
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS Roland Ave. & Rectory Lane
e. IS RESIDENCE ON A FARM? <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) MARGARETTA R. HOLLYDAY | | 4. DATE OF DEATH
Month December Day 26 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 23, 1884 |
| 9. AGE (In years last birthday) 83 | | 10. IF UNDER 1 YEAR
Months 8 Days 3 Hours 15 Min. 00 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hostess | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11. BIRTHPLACE (County & State, or foreign country) Easton, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME
Henry Hollyday | | 14. MOTHER'S MAIDEN NAME
Margaretta Chilton | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-05-9963 | |
| 17. INFORMANT
A Miss Rosalie Hollyday Memorial Apt | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of thyroid
DUE TO (b) 194X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct , 1967, to Dec 26 , 1967, that (I) (we) last saw the deceased alive on Dec 26 , 1967, and that death occurred at 330 P M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John A Nesbitt, Jr. | | 22b. DATE SIGNED
12-26-67 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN A NESBITT, JR | | 22d. ADDRESS
1009 Frederick Rd. Balt. 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF
12-29-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Spring Hill | | 23d. LOCATION (City or Town) (County) (State)
Easton, Maryland | |
| 24. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home, Inc, 6500 York Rd. Baltimore, Md. 21212 | | ADDRESS
15 REC'D BY REGISTRAR 3 1968 | |

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Baltimore

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GENERAL OF STATE

December 25, 1855

Female White

July 25, 1855

Hostess

Hostess

Hostess

Henry Holiday

Henry Holiday

Henry Holiday

Henry Holiday

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Henry Holiday

Henry Holiday

Henry Holiday

16558

CERTIFICATE OF DEATH

16551

| | | | |
|--|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Jullerton</u> | | c. LENGTH OF STAY IN lb
<u>03-1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>22 Mc Cormick Avenue</u> | | d. STREET ADDRESS
<u>22 McCormick Ave.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Francis</u> Middle <u>E.</u> Last <u>Holmes</u> | | 4. DATE OF DEATH
Month <u>December</u> Day <u>31</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>4/7/1898</u> |
| 9. AGE (In years last birthday)
<u>69</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Machinist (Ret)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Connecticut</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Francis H. Holmes</u> | | 14. MOTHER'S MAIDEN NAME
<u>Laura M. Harvey</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>042091875</u> | |
| 17. INFORMANT
<u>Mrs. Alma E. Holmes- Same</u> | | Address
<u> </u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201</u>
DUE TO <u>Acute coronary myocardial infarction</u>
(b) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO <u>10 yrs.</u>
(c) <u>with coronary insufficiency</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>20 mins.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u> </u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
<u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>67</u> , to <u>Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 18</u> , 19 <u>67</u> , and that death occurred at <u>5:15 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Charles M. Kerr</u> M.D. | | 22b. DATE SIGNED
<u>Jan 2, 67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Charles M. Kerr</u> | | 22d. ADDRESS
<u>6801 Belair Rd. Balto Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>1/4/68</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Moreland Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore Co, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | | 25a. REC'D BY REGISTRAR
DATE <u>AN 4 1968</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16559

16552

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | c. LENGTH OF STAY IN lb <u>10 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med. Center</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Ethel Wineford Hopkins</u> | | 4. DATE OF DEATH <u>12 22 19 67</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>Can</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-21-07</u> |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Delta, Pa.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Delta, Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Edward Hughes</u> | | 14. MOTHER'S MAIDEN NAME <u>Lloyd.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>UNK</u> | |
| 17. INFORMANT <u>Harold R. Hopkins</u> | | Address <u>11 N. Kelly Ave Bel Air, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>
DUE TO <u>170X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Secondary to Pulmonary metastasis</u>
DUE TO <u>Secondary to CARCINOMA BREAST.</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>12/13/67</u>
<u>12/22/67</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-13-1967</u> , to <u>12-22-1967</u> , that (I) (we) last saw the deceased alive on <u>12-22-1967</u> , and that death occurred at <u>12-10AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Dipak Kumar Mallik</u> | | 22b. DATE SIGNED <u>Dec. 22, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>DIPAK KUMAR MALLIK</u> | | 22d. ADDRESS <u>Greater Baltimore Medical Center</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Dec. 24, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>State Ridge Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Delta York Pa.</u> |
| 24. FUNERAL DIRECTOR <u>John H. Harkins</u> | | 25a. RECEIVED BY REGISTRAR <u>DEC 27 1967</u> | |
| ADDRESS <u>Delta, Pa.</u> | | 25b. REGISTRAR'S SIGNATURE <u>James Judge</u> | |

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RECEIVED OF DEATH

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RECEIVED OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16560

16553

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | c. LENGTH OF STAY IN 1b
One Year | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
7929 Lynch Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Gladys Fannie Howard | | 4. DATE OF DEATH
Month December Day 6 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 12, 1901 |
| 9. AGE (In years last birthday)
66 yrs. | | 10. IF UNDER 1 YEAR
Months 03 Days -1 Hours 00 Min. 00 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
West Virginia | |
| 11. BIRTHPLACE (State or foreign country)
U. S. A. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Charles Whittke | | 14. MOTHER'S MAIDEN NAME
Ella Childres | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
234-38-6633D | |
| 17. INFORMANT (Daughter)
Mrs. Edna E. McCartney, 7929 Lynch Rd. | | Address Dundalk, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1561 IMMEDIATE CAUSE (a) CArcinoma of Liver
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
10 mos | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
None | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Melvin B. Davis
EXAMINER'S NAME (Type)
M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningson Rd.
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Dundalk,
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Md. 21222
Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/9/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Lake View Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Carroll Co. Md. | |
| 24. FUNERAL DIRECTOR
John J. Duda, 7922 Wise Ave. Dundalk, Md. | | 25a. REC'D BY REGISTRAR
DATE DEC 11 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16561

16554

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland b. COUNTY
Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville | | c. LENGTH OF STAY IN days
days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
506 Seminary Ave. | | d. STREET ADDRESS
506 W. Seminary Ave. | |
| 3. NAME OF DECEASED
(Type or print)
LORRIE ANN HOWARD | | 4. DATE OF DEATH
December 11 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 25, 1967 |
| 9. AGE (In years lost birthdate)
795.5 | | 10. IF UNDER 1 YEAR
Months 7 Days 16 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Howard | | 14. MOTHER'S MAIDEN NAME
Loretta Ross | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
 | |
| 17. INFORMANT
Mr. Goerge Howard, Same as # 2 | | Address
 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden unexpected death in infancy
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
 | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
 | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
 | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
 | | 20f. (City or town) (County) (State)
 | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22. DATE SIGNED
December 11, 1967 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Dec. 14, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cockeysville, Maryland | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204 | | 25a. REC'D BY REGISTRAR
DEC 19 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 25c. REGISTRAR'S SIGNATURE
 | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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| 16562 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17889 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|-----------|--|--|--|--|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | | | | | | | | First Middle Last | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CLYDE Allison ISENNOCK | | | | | | | | | | | | | | | | | | | | Month Day Year | | | | | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | | | | | | | | | 2c. DATE PRONOUNCED DEAD | | | | | | | | | | 2d. HOUR | | | | | | | | | |
| Male | | | | | | | | | | White | | | | | | | | | | 2/9/1904 | | | | | | | | | | 63 YRS 11 | | | | | | | | | | | | | | | | | | | | Month Day Year | | | | | | | | | | 1968 5:10 | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | U.S.A. | | | | | | | | | | Baltimore | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Parkton Baltimore | | | | | | | | | | about 100 ft. W of Rt. 45 | | | | | | | | | | Laborer | | | | | | | | | | Farm | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Baltimore | | | | | | | | | | Hyde | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| John Thomas Isennock | | | | | | | | | | Victorine Coe | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 16c. INFORMANT | | | | | | | | | | 16d. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | 193-18-5519 | | | | | | | | | | Mrs. William E. Standiford | | | | | | | | | | 117 Gibbons Blvd. 21030 Cockeysville, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | Asphyxia due to hanging | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 974x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY Month, Day, Year | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | ? P.M. ? 19 | | | | | | | | | | Subject hanged himself | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. | | | | | | | | | | City or Town | | | | | | | | | | County | | | | | | | | | | State | | | | | | | | | | | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | | | | | Tree | | | | | | | | | | 100 ft. W of Rt. 45 | | | | | | | | | | Baltimore | | | | | | | | | | Balto. Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: | | | | | | | | | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | CHIEF MEDICAL EXAMINER | | | | | | | | | | 22b. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) | | | | | | | | | | M.D. | | | | | | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | January 17, 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Edward F. Wilson, M.D. | | | | | | | | | | | | | | | | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) | | | | | | | | | | (County) | | | | | | | | | | (State) | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | 1/19/1968 | | | | | | | | | | Ebenezer | | | | | | | | | | Rutledge, Harford, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Charles E. Kurtz | | | | | | | | | | Jarrettsville, Md. | | | | | | | | | | JAN 19 1968 | | | | | | | | | | [Signature] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

16563

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16555

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND ✓
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TOWSON | | c. LENGTH OF STAY IN 1b
30 1/2 | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | d. STREET ADDRESS
4307 GLEN ARM AVE. #21206 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. JOSEPH HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
RICHARD RAYMOND JENKINS | | 4. DATE OF DEATH
Month Day Year
DECEMBER 24 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
DECEMBER 15, 1889 |
| 9. AGE (In years lost birthday)
78 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
24 19 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Assist. Agent Penna. R.R. | | 10b. KIND OF BUSINESS OR INDUSTRY
INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William Jenkins | | 14. MOTHER'S MAIDEN NAME
Katherine | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
717-07-9522 | |
| 17. INFORMANT
Mrs Pearl Jenkins | | Address
Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) CONGESTIVE HEART FAILURE
DUE TO
(c) EMPHYSEMA | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from DECEMBER 23, 1967 , to DECEMBER 24, 1967 that (I) (we) lost saw the deceased alive on DECEMBER 24, 1967 , and that death occurred at 3:00AM from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
[Signature] M.D. | | 22b. DATE SIGNED
DECEMBER 24, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
ISMAEL JAMORA, M.D. | | 22d. ADDRESS
7620 YORK ROAD TOWSON, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12/27/67 | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland |
| 24. FUNERAL DIRECTOR
Leonard J Ruck Inc. 5305 Harford Rd. | | 25a. REC'D BY REGISTRAR
DATE DEC 27 1967 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

18583

18583

DEPARTMENT OF COMMERCE



18583-18584

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|----------------------------------|---|---|--|-----------------------------------|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 16564 CERTIFICATE OF DEATH 16556 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Howard | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonville | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Ellicott City | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Shangri La. Nursing Home | | | | | d. STREET ADDRESS
Folly Quarter Rd. | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Allan Middle Johnson Last | | | | | 4. DATE OF DEATH
Month Dec. Day 5 Year 1967 | | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5/6/88 | | 9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Med. Director | | | 10b. KIND OF BUSINESS OR INDUSTRY
Doctor | | 11. BIRTHPLACE (County & State, or foreign country)
Mass | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Frederick Johnson | | | | | 14. MOTHER'S MAIDEN NAME
Ella Kimball | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | | 16. SOCIAL SECURITY NO.
? | | 17. INFORMANT
Mrs. Mary Bennett Ellicott City, Md. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
446X
DUE TO (b) Nephrosclerosis
DUE TO (c) Generalized Arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
CVA in C. side Hemiparesis | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 10-1-1967 , to 12-6-1967 , that (I) (we) last saw the deceased alive on 12-5-1967 , and that death occurred at 3 P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Cesar Valle Cervero | | | | | 22b. DATE SIGNED
12-6-67 | | | 22c. PHYSICIAN'S NAME (Type)
CESAR VALLE CAVERO | |
| 22d. ADDRESS
8629 Liberty Rd. Randalstown | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
CREMATION | | | 23b. DATE THEREOF
12-6-67 | | 23c. NAME OF CEMETERY OR CREMATORY
LEE FUNERAL Home | | 23d. LOCATION (City, town or county) (State)
Washington, D.C. | | |
| 24. FUNERAL DIRECTOR
Higginbotham-Slack
Funeral Home | | | | | 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |
| ADDRESS
Ellicott City | | | | | DATE
DEC 11 1967 | | | | |

1855

STATE DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
|--|--|---|--|---|--|---|--|
| 16565 | | | | CERTIFICATE OF DEATH | | | |
| 16557 | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY BALTO. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
63-1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
FOREST HAVEN NURSING HOME | | | | d. STREET ADDRESS
905 Bengies Rd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ANNIE Middle E Last JONES | | | | 4. DATE OF DEATH
Month Dec. Day 29 Year 1967 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 29 1888 | |
| 9. AGE (In years last birthday) yrs.
79 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
AT HOME | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME
JOHN WANDBY | | | |
| 14. MOTHER'S MAIDEN NAME
MARY GENSRING | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO.
213-05-3776 | | | | 17. INFORMANT
MRS ALTHEA V. OBERLE-905 BENIGIES RD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 MYOCARDIAL INFARCTION
DUE TO (b) MYOCARDIAL INFARCTION - CORONARY ARTERIO-SCLEROSIS
DUE TO (c) DISEASE | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from 1/1 , 19 67 , to 12/29 , 19 67 , that (I) (we) last saw the deceased alive on 12/29 , 19 67 , and that death occurred at 2:30 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
John W. Shaw | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
12/29/67 | |
| 22c. PHYSICIAN'S NAME (Type)
John W. Shaw | | | | 22d. ADDRESS
6800 EDWARDS AVE. BALTIMORE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
1/2/68 | | 23c. NAME OF CEMETERY OR CREMATORY
OAK LAWN | | 23d. LOCATION (City or Town) (County) (State)
COLGATE MD | |
| 24. FUNERAL DIRECTOR
Raymond Hughes
USGRICH FUNERAL HOME | | | | 25a. REC'D BY REGISTRAR
PMS
Wellsch Funeral Home | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| DATE JAN 5 1968 | | | | | | | |

1855

CERTIFICATE OF DEATH

1855

John W. Carey

Barre

John W. Carey

John W. Carey

John W. Carey

John W. Carey

Barre

1855

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16566

16558

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY DORCHESTER | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
26 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS
406 OAKLEY STREET | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
BERNARD M. JONES | | 4. DATE OF DEATH
Month Day Year
DECEMBER 6 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/11/1901 |
| 9. AGE (In years last birthday) yrs.
66 | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BUTCHER | | 10b. KIND OF BUSINESS OR INDUSTRY
Grocery Store | |
| 11. BIRTHPLACE (County & State, or foreign country)
DORCHESTER CO. MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
FIELDER G. JONES | | 14. MOTHER'S MAIDEN NAME
LILLIE PARTRIDGE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | 16. SOCIAL SECURITY NO.
215 03 54 68 | |
| 17. INFORMANT
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ADENOCARCINOMA OF PROSTATE WITH METASTASES
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/10/67 , 19__, to 12/6/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/6/67 , 19__, and that death occurred at 2:50P M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
George Dudas | | 22b. DATE SIGNED
12/6/67 | |
| 22c. PHYSICIAN'S NAME (Type)
GEORGE DUDAS, M. D. | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Dec 9, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Greenlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cambridge, Maryland | |
| 24. FUNERAL DIRECTOR
LECOMPT FURNAL HOME | | 25a. REC'D BY REGISTRAR
DEC 11 1967 | |
| ADDRESS
CAMBRIDGE, MARYLAND | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1858

CHURCH OF DEATH

1858

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
c. LENGTH OF STAY IN 1b 21212
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 66 Dunkirk Road | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 66 Dunkirk Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First George Middle T. Last Jones | | 4. DATE OF DEATH
Month Dec Day 12 Year 19 67 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-19-1879 |
| 9. AGE (In years last birthday) 88 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Repair-Owner | | 10b. KIND OF BUSINESS OR INDUSTRY Garage | |
| 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Thomas Jones | | 14. MOTHER'S MAIDEN NAME Mary E. McCullough | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 218-54-3917 | |
| 17. INFORMANT Mrs. Harry Runyan | | Address Above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 15 to Dec 12 , 19 67 , that (I) (we) last saw the deceased alive on Dec 11 , 19 67 , and that death occurred at 4:20 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Dr. Wm. G. Helfrich | | 22b. DATE SIGNED 12-13-67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Wm. G. Helfrich | | 22d. ADDRESS 5006 Roland Ave., Balto., Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-15-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Woodlawn | | 23d. LOCATION (City, town or county) (State) Woodlawn Md. | |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | 25a. REC'D BY REGISTRAR DEC 13 1967 | |
| ADDRESS 4905 York Rd., Balto. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

1850

1850

STATE OF NEW YORK

IN SENATE,
January 18, 1850.
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE,
IN ANSWER TO A RESOLUTION
PASSED BY THE SENATE,
MAY 18, 1849.
ALBANY:
J. B. LEECH, PRINTER,
1850.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15MA (5)
6M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | | | c. LENGTH OF STAY IN lb
8 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | | | 15-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rosewood State Hospital | | | | | | d. STREET ADDRESS
Stewart Lane | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Robin - JONES | | | | | | 4. DATE OF DEATH
Month Day Year
12 17 19 67 | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11-3-57 | | 9. AGE (In years last birthday)
10 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
10 17 19 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dependent | | | | 10b. KIND OF BUSINESS OR INDUSTRY
none | | 11. BIRTHPLACE (State or foreign country)
Montgomery Co., Md. | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Walter Jones | | | | | | 14. MOTHER'S MAIDEN NAME
Frances Louise Poge | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no -- | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT Address
Rosewood Records, Owings Mills, Maryland | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
9217 IMMEDIATE CAUSE (a) asphyxia due to food aspiration
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
aspirational Pneumonia. | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
child aspirated food. | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. Dec 17 1967 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
Rosewood State Hospital | | 20f. (City or town) (County) (State)
Owings Mills, Md. | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE D. D. Caples M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) D. D. Caples, M.D. | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | Address (Street, city, town or county) Reisterstown, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/21/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Rosewood Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Owings Mills, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS
J. F. Eline & Sons Reisterstown, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 26 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16569

CERTIFICATE OF DEATH

16561

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TOWSON
c. LENGTH OF STAY IN 1b
Days
58
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. JOSEPH HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE
d. STREET ADDRESS
425 MURDOCK ROAD #21212
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
ANNA ALICE KANE | | 4. DATE OF DEATH
Month Day Year
DECEMBER 18 19 67 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MAY 30, 1889
9. AGE (In years last birthday)
78 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 11. BIRTHPLACE (County & State, or foreign country)
HARRISONBURG, VA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Edward Lucas Russell | | 14. MOTHER'S MAIDEN NAME
Louella Gaines | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220 44 0385 | |
| 17. INFORMANT
Mr. James E. Kane, Jr. | | Address
1134 Gypsy Lane West Towson, Maryland 21204 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE GENERALIZED ARTERIOSCLEROSIS
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from DECEMBER 9, 1967 , to DECEMBER 18, 1967 that (I) (we) last saw the deceased alive on DECEMBER 18 1967 , and that death occurred at 4:20 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Gualberto Gokim Jr.</i>
22c. PHYSICIAN'S NAME (Type)
GUALBERTO GOKIM, JR., M.D. | | 22b. DATE SIGNED
DECEMBER 18, 1967 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Dec. 20, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery |
| 23d. LOCATION (City or Town) (County) (State)
Pikesville, Maryland | | 24. FUNERAL DIRECTOR
ADDRESS
Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204 | |
| 25a. REC'D BY REGISTRAR
DATE
DEC 22 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16570

CERTIFICATE OF DEATH

16562

| | | | | | | | |
|--|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore 21237</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>1805 Green Castle Drive</u> | | | | d. STREET ADDRESS
<u>1805 Green Castle Drive</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Joseph</u> Middle <u>William</u> Last <u>Kaufmann</u> | | | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>12</u> Year <u>1967</u> | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 28, 1901</u> | 9. AGE (In years last birthday)
<u>66</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Policeman</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>Joseph F. Kaufmann</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Sophia Scheutler</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>220-36-3293</u> | | 17. INFORMANT
Address
<u>Mrs. Catherine A. Kaufmann (Same)</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Acute Coronary Occlusion</u>
DUE TO (b) <u>Coronary Artery Disease, Atherosclerotic</u>
DUE TO (c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u> </u> p.m. <u>19</u> | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , to <u>12/12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/12</u> , 19 <u>67</u> , and that death occurred at <u>10 A</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>John G. Orth, M.D.</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>12/12/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>John G. Orth</u> | | | | 22d. ADDRESS
<u>8019 Philadelphia Rd.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>12/16/67.</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Cross Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Leonard J. Ruck, Inc Baltimore, Md.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 15 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. [Signature]</u> | |

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RECORDS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|------------------|---------------|---|---|---|-------------|--|--------------------------|--|--|
| 16571 | | | | | 16563 | | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | | |
| a. COUNTY
Baltimore | | | | | a. STATE
Maryland | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | b. COUNTY
Baltimore | | | | | | |
| c. LENGTH OF STAY IN 1b | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | d. STREET ADDRESS | | | | | | |
| Ridgeway Manor Nursing Home | | | | | 104 North Hilton Street | | | | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | First | | Middle | | Last | | 4. DATE OF DEATH | | |
| | | | Bessie | | May | | Kaye | | Month
December | | |
| | | | | | | | | | Day
20 | | |
| | | | | | | | | | Year
1967 | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| Female | | White | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | May 4, 1879 | | 88 yrs. | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) | | | |
| Housewife | | | | | | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| | | | | Charles E. Jamison | | | | Ellen M. Ferguson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | | | 17. INFORMANT Address | | | |
| | | | | 216-46-5691 | | | | Elizabeth Sherman 301 McMechen St. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| | | | | | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1 Nov, 1967 , to 20 Dec, 1967 , that (I) (we) last saw the deceased alive on 20 Dec, 1967 and that death occurred at 11 M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
William Gasman | | | | | | | | | | 22b. DATE SIGNED
21 Dec 67 | |
| 22c. PHYSICIAN'S NAME (Type)
153X J. L. PHILLIPS JR. MD | | | | | | | | | | 22d. ADDRESS
1331 Dulles Lane RD-2122 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City, town or county) (State) | |
| Burial | | | | 12/23/67 | | Loudon Park Cemetery | | | | Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Wm. J. Tinkner Sons North Pa. | | | | | | 25a. REC'D BY REGISTRAR
DEC 27 1967 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|-------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 16572 | | | | | | CERTIFICATE OF DEATH | | | 16564 | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson 21204 | | | | c. LENGTH OF STAY IN 1b
4 mons 27 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
11214 York Road, Cockeysville, Md | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Dulaney Towson Nursing Home | | | | | | d. STREET ADDRESS
11214 York Road | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Dan Bosley Kelley | | | | | | 4. DATE OF DEATH
Month December Day 20 Year 1967 | | | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH
12/19/1884 | | 9. AGE (In years lost birthday)
83 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
salesman-dis. Manager | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Rumford Chemical | | 11. BIRTHPLACE (County & State, or foreign country)
Belfast, Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William H. Kelley | | | | | | 14. MOTHER'S MAIDEN NAME
Annie Brooks | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO.
037-01-1048A | | 17. INFORMANT
Address 21204 Dulaney Towson Nursing Home, 111 West Road | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Pyelonephritis (Calculus) with Uremia
DUE TO 600,0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO _____
(c) _____
INTERVAL BETWEEN ONSET AND DEATH 15 years + | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Bronchopneumonia | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19 p.m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1945 , to DEC 20, 1967 , that (I) (we) last saw the deceased alive on DEC 19 1967 , and that death occurred at 1:40 P.M. , from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Robert W. Garis | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
12/20/67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
ROBERT W. GARIS, M.D. | | | | | | 22d. ADDRESS
12 E. EAGER ST. BALTO., MD. 21202 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Dec. 22, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Black Rock Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co., Maryland | | | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204 | | | | | | 25a. REC'D BY REGISTRAR
DEC 21 1967 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

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DEPARTMENT OF HEALTH

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16573 CERTIFICATE OF DEATH 16565

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
e. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Pikesville 8, Md.</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Pikesville 21208</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>1708 Reisterstown Rd., Pikesville, Md.</u> | | d. STREET ADDRESS
<u>1708 Reisterstown Road</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Michael</u> Middle <u>John</u> Last <u>Kelly</u> | | 4. DATE OF DEATH
Month <u>Dec</u> Day <u>14</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 14, 1894</u> |
| 9. AGE (In years last birthday)
<u>73</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Government</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>Newburyport, Mass.</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>Charles P. Kelly</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Mary McQuade</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>Yes</u> <u>W.W.I</u> | |
| 16. SOCIAL SECURITY NO.
<u>218-36-4708</u> | | 17. INFORMANT
<u>Mrs. Sarah Donlevy Kelly, 1708 Reisterstown Rd.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
<u>5371</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
(c)
<u>Pulmonary emphysema, severe</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>Several years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12 Dec 1967</u> to <u>14 Dec 1967</u> , that (I) (we) last saw the deceased alive on <u>12 Dec 1967</u> , and that death occurred at <u>6:57 AM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Paul H Royse</u> M.D. | | 22b. DATE SIGNED
<u>Dec 14 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Paul H Royse</u> | | 22d. ADDRESS
<u>1403 Foley La. Pikesville, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>Dec. 18, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Mary's Cemetery</u> | 23d. LOCATION (City, town or county) (State)
<u>Newburyport, Mass.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Frank A. Newell, Pikesville, Md.</u> | | 25a. REC'D BY REGISTRAR
<u>DEC 18 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>James J. Judge</u> | | | |

85204

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|------------------------------|--|-------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 16574 | | | |
| 16566 | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mount Wilson
c. LENGTH OF STAY IN 1b
19 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Mount Wilson State Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Elkton
d. STREET ADDRESS
210 Friendship Rd
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
ELLIS First SAMUEL Middle KILMON Last | | 4. DATE OF DEATH
Month 12 Day 18 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-9-1890 |
| 9. AGE (In years last birthday) yrs.
77 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lineman | | 10b. KIND OF BUSINESS OR INDUSTRY
ELECTRIC | |
| 11. BIRTHPLACE (County & State, or foreign country)
Columbia, Pa | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
SAMUEL KILMON | | 14. MOTHER'S MAIDEN NAME
GEORGIA CROSLY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
UNKNOWN | | 16. SOCIAL SECURITY NO.
216-07-1810 | |
| 17. INFORMANT
Records, Mt. Wilson State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
527.1 IMMEDIATE CAUSE (a) Congestive Heart failure - Respiratory insufficiency
DUE TO (b) Cor Pulmonale, chronic
DUE TO (c) Obstructive emphysema, pulmonary
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11-29 , 19 67 , to 12-18 , 19 67 , that (I) (we) lost saw the deceased alive on 12-18 19 67 , and that death occurred at 7:20 M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Wm. Newcomer | | 22b. DATE SIGNED
12/18/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Wm. Newcomer, M.D., Superintendent | | 22d. ADDRESS
Mount Wilson, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12/20/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
MT. ERIN | | 23d. LOCATION (City or Town) (County) (State)
HAVER DE GRACE, MD. | |
| 24. FUNERAL DIRECTOR
Ryger Funeral Home | | 25a. REC'D BY REGISTRAR
DEC 20 1967 | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | 25c. ADDRESS
259 ELKTON MAIN ST. | |

18534

18534

Baltimore

Mount Wilson

Mount Wilson State Hospital

Ellis

Ellis

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18534

GEORGIA CRYSTAL

KILMAN

Records, Mt. Wilson State Hospital

Mount Wilson, Maryland

Mr. Newcomer, M.D., Superintendent

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16575

16567

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY
BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TOWSON
c. LENGTH OF STAY IN lb
ESSEX
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. JOSEPH HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ESSEX
d. STREET ADDRESS
410 TORNER ROAD #21221
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
CORNELIUS KEITH KING, SR. | | 4. DATE OF DEATH
Month Day Year
DECEMBER 6 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
DECEMBER 18, 1920 |
| 9. AGE (In years last birthday)
46 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min.
19 67 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SALESMAN | | 12. KIND OF BUSINESS OR INDUSTRY
BREVARD, NORTH CAROLINA | |
| 13. FATHER'S NAME
CARR W. KING | | 14. MOTHER'S MAIDEN NAME
JULIA JONES | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW II | | 16. SOCIAL SECURITY NO.
250-03-5250 | |
| 17. INFORMANT
ANNE KING | | Address
410 TORNER RD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
DUE TO (b) primary in pancreas
DUE TO (c) primary in pancreas
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Pulmonary thrombo embolism | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCTOBER 20, 19 67 , to DECEMBER 6 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 6 19 67 , and that death occurred at 4:00 A.M. , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Reynaldo Orjuela-Gomez, M.D. | | 22b. DATE SIGNED
12/6/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Reynaldo Orjuela-Gomez, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE-THEREOF
12/9/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
PARKWOOD | | 23d. LOCATION (City or Town) (County) (State)
BALTO. MD | |
| 24. FUNERAL DIRECTOR
J.B. CONNELLY SONS | | 25a. REC'D BY REGISTRAR
300 MACE | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | DATE
DEC 8 1967 | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16576

16568

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|---|--|--|---|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY BALTO | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21234 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. JOSEPH HOSPITAL | | | | d. STREET ADDRESS
1709 Edgewood Rd. | | | |
| 3. NAME OF DECEASED
(Type or print) Elizabeth L. KING | | | | 4. DATE OF DEATH
Month December Day 21 Year 1967 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 3, 1906 | | 9. AGE (In years lost birthday) yrs. 61 | | 10. IF UNDER 1 YEAR
Months 6 Days 1 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker & School Teacher | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Arthur A. Rencher | | | | 14. MOTHER'S MAIDEN NAME
Helen Hibler | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO.
219-36-5880 | | 17. INFORMANT
Mr. Melvin T. King 1709 Edgewood Rd. 34 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 330x Massive intra-cerebral hemorrhage
DUE TO (b) Rupture of a Berry cerebral aneurysm.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | By Family Permission (State) |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | 22. DATE SIGNED
12/22/67 |
| ACTUAL SIGNATURE
Charles F. O'Donnell, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/24/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
J. F. Eline & Sons Reisterstown, Md. | | | | 25a. REC'D BY REGISTRAR
DEC 26 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16577

CERTIFICATE OF DEATH

16569

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>RURAL</u> | | c. LENGTH OF STAY IN lb
<u>9 MOS</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>LUTHERVILLE</u> | | 03-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>STELLA MARIS HOSPICE</u> | | d. STREET ADDRESS
<u>101 GOTHARD RD</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>EMMA</u> Middle <u>HOFFMAN</u> Last <u>KIRKNER</u> | | 4. DATE OF DEATH
Month <u>Dec</u> Day <u>7</u> Year <u>1967</u> | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>NOV 29, 1886</u> |
| 9. AGE (In years last birthday)
<u>81</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>7</u> Days <u>6</u> Hours <u>7</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>BALTIMORE, MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>BERNARD HOFFMAN</u> | | 14. MOTHER'S MAIDEN NAME
<u>AMELIA HOELSTEIN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>216-018178</u> | |
| 17. INFORMANT
<u>HOSPICE RECORDS</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute myocardial infarct</u>
DUE TO (b) <u>Asen</u>
DUE TO (c) <u>Asen</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/7</u> , 19 <u>67</u> , to <u>12/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/6</u> , 19 <u>67</u> and that death occurred at <u>8:05 PM</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Robert J. Mahon</u> | | 22b. DATE SIGNED
<u>12/18/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>ROBERT J. MAHON, M.D.</u> | | 22d. ADDRESS
<u>204 E. Joppa Road Towson, Md. 21204</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>DEC. 11, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>St. STEPHENS CEM.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>BRADSHAW MARYLAND</u> | |
| 24. FUNERAL DIRECTOR
<u>RAYMOND CURRAN</u> | | 25a. REC'D BY REGISTRAR
<u>807 E. CARLETON DR. TOWSON, MD 21204</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE
<u>DEC 26 1967</u> | |

1853

UNIVERSITY OF CHICAGO

1853

Received of the Treasurer of the University of Chicago
the sum of \$100.00
for the purchase of books
for the Library of the University of Chicago
this 1st day of January 1853

Witness my hand and seal this 1st day of January 1853
John D. Johnston
Treasurer of the University of Chicago

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| BALTIMORE | | BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3524 LANGREHR ROAD, APT 1D, LIBERTY WEST | | d. STREET ADDRESS LIBERTY WEST APTS. 3524 LANGREHR ROAD, APT. 1D | |
| 3. NAME OF DECEASED (Type or print) FAVE KLAUVENS | | 4. DATE OF DEATH DECEMBER 13, 1967 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-24-1890 |
| 9. AGE (In years lost birthday) 77 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME MORRIS LIPSITZ | | 14. MOTHER'S MAIDEN NAME ROSE ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT MR. LOUIS KLAUVENS, 3524 LANGREHR RD., APT. 1D | | 18. ADDRESS LIBERTY WEST APTS. #21207 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronoclerotic Heart Disease
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour "o.m.
p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 10/16 , 1965, to 12/13 , 1967, that (I) (we) last saw the deceased alive on 12/6 , 1967, and that death occurred at 7:30 A M, from causes and on the date stated above | | | |
| 22a. SIGNATURE DR. ALBERT HIMELFARB | | 22b. DATE SIGNED 12/13/67 | |
| 22c. PHYSICIAN'S NAME (Type) DR. ALBERT HIMELFARB | | 22d. ADDRESS 3501 ST. PAUL STREET | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 12-14-67 | 23c. NAME OF CEMETERY OR CREMATORY BETH HAMEDROSH HAGODOL | 23d. LOCATION (City or Town) (County) (State) ROSEDALE, MARYLAND |
| 24. FUNERAL DIRECTOR SOL KLEVINSON & BROS. INC., 6010 REISTERSTOWN RD. | | 25a. REC'D BY REGISTRAR Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE | | DATE DEC 18 1967 | |

1857

1857

BALTIMORE

BALTIMORE

BALTIMORE

3224 LARGENTH ROAD, APT. 15, LIBERTY WEST APTS.
3224 LARGENTH ROAD, APT. 15

15, DECEMBER 1957

WHITE

1-1-1950

77

BALTIMORE

BALTIMORE

LIBERTY WEST APTS.

LIBERTY WEST APTS.
3224 LARGENTH ROAD, APT. 15

3201 ST. PAUL STREET

DR. ALBERT WINTER

10-11-57 NEW HARBOR HARBOR ROSSELL, WYOMING

301 KILBURN - 301 KILBURN - 301 KILBURN

CERTIFICATE OF DEATH

16579

16571

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore, Md.
Baltimore, MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Randallstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Balto. Cnty. General Hospital | | d. STREET ADDRESS 3711 Valley Hill Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Oscar, Middle KLEIN Last [REDACTED] | | 4. DATE OF DEATH
Month Dec. Day 6 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/27/23 |
| 9. AGE (In years last birthday)
44 yrs. | | 10. BIRTHPLACE (County & State, or foreign country)
Balto. Md. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Shoery | | 10b. KIND OF BUSINESS OR INDUSTRY
Retail | |
| 11. FATHER'S NAME
Harry Klein | | 12. MOTHER'S MAIDEN NAME
SARAH Gordon | |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No. | | 14. SOCIAL SECURITY NO.
218-18-3477 | |
| 15. INFORMANT
Mrs. Marian Klein - 3711 Valley Hill Dr. | | Address Randallstown | |
| 16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE
DUE TO (c) [REDACTED] | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
SEVERE HYPOTHYROIDISM SECONDARY TO COMPLETE THYROIDECTOMY FOR THYROID MALIGNANCY | | | |
| 17a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 16.) | |
| 18a. TIME OF INJURY
Hour a.m. 19
p.m. | 18b. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 18c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 18d. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12-6-1967 , to 12-6-1967 , that (I) (we) saw the deceased alive on 12-6-1967 , and that death occurred at 6:30 PM , from causes on and the date stated above. | | | |
| 22a. SIGNATURE
Joseph Deckelbaum, M.D. | | 22b. DATE SIGNED
12-6-67 | |
| 22c. PHYSICIAN'S NAME (Type)
JOSEPH DECKELBAUM, M.D. | | 22d. ADDRESS
3502 WEST ROGERS AVE. BALTO. 21215 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12/7/67 | 23c. NAME OF CEMETERY OR CREMATORY
Liberty Park Cemetery | 23d. LOCATION (City or Town) (County) (State)
Randallstown Md. |
| 24. FUNERAL DIRECTOR
Sal Lerman & Bros Inc. 6010 Randallstown Rd | | 25a. REC'D BY REGISTRAR
DEC 8 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles J. [REDACTED] | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

A34
4/18/68

1823

1821

~~CONFIDENTIAL~~

~~CONFIDENTIAL~~

~~CONFIDENTIAL~~

~~CONFIDENTIAL~~

Acute Myocardial Infarction

Hypertensive Cardiovascular Disease

Severe Hypothyroidism For Thyroid Replacement

15-6-61

601

15-6-61

Joseph Decker
Joseph Decker, M.D.

3205 West 12th Ave. Denver, Colo.

12/1/61
12/1/61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16580
16572
CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
c. LENGTH OF STAY IN 1b
8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Greater Baltimore Medical Center | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson
d. STREET ADDRESS
105 Shealy Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Edna Virginia Kling | | 4. DATE OF DEATH
Month Day Year
12 13 1967 | |
| 5. SEX
Female | | 6. COLOR OR RACE
Cau. | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1/31/11 | |
| 9. AGE (In years last birthday)
57 56 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
57 56 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
George Kyger | | 14. MOTHER'S MAIDEN NAME
unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
na none | | 16. SOCIAL SECURITY NO.
229-14-6575 | |
| 17. INFORMANT
Family records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subarachnoid hemorrhage
330X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Ruptured Berry aneurysm of Circle of Willis
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/6 , 19 67 , to 12/13 , 19 67 , that (I) (we) last saw the deceased alive on 12/13 , 19 67 , and that death occurred at 9:45M , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
John E. Adams | | 22b. DATE SIGNED
12/13/67 | |
| 22c. PHYSICIAN'S NAME (Type)
John E. Adams, M.D. | | 22d. ADDRESS
6701 N. Charles Street | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/18/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Immanuel Church Cemetery | | 23d. LOCATION (City, town or county) (State)
Glenore Md. | |
| 24. FUNERAL DIRECTOR
John Burns Sons | | 25a. REC'D BY REGISTRAR
DEC 18 1967 | |
| ADDRESS
Towson | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1850

11 = 11

John E. Allen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16581

16573

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
103-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | e. STREET ADDRESS
10 W. Elm Avenue 21206 | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
GEORGE L KLINK, JR. | | 4. DATE OF DEATH
Month Day Year
December 17 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-28-27 |
| 9. AGE (In years lost birthday) yrs.
40 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George L. Klink Sr. | | 14. MOTHER'S MAIDEN NAME
Hessie V. Moseman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-24-2069 | |
| 17. INFORMANT
Sister - Margaret Pierpoint | | Address
same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
260x IMMEDIATE CAUSE (a) Uremia
DUE TO (b) Diabetic Glomerulo-sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Diabetes Mellitus | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-15 , 19 67 , to 12-17 , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12-17 , 1967, and that death occurred at 11:40 a.m. from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Lawrence Misanik, M.D. | | 22b. DATE SIGNED
12-17-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Lawrence Misanik, M.D. | | 22d. ADDRESS
7620 York Road, Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12-20-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co. Md. |
| 24. FUNERAL DIRECTOR
Lessaun Funeral Home 7401 Belair Road | | 25a. REC'D BY REGISTRAR
DEC 22 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

18281

CENTRAL OF CALIF.

1021

TO THE BOARD OF DIRECTORS

FROM THE BOARD OF DIRECTORS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16582

CERTIFICATE OF DEATH

16574

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | c. LENGTH OF STAY IN lb
Days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21212 | | d. STREET ADDRESS
512 Dunkirk Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
5470 Addington Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Walter Ray Knaube | | 4. DATE OF DEATH
December 12, 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 2, 1895 |
| 9. AGE (In years lost birthday)
72 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Manager/Manager | | 10b. KIND OF BUSINESS OR INDUSTRY
RESTAURANT | |
| 11. BIRTHPLACE (County & State, or foreign country)
Penna. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
162-22-1334 | |
| 17. INFORMANT
Mrs. Pearl Knaube, Same as # 2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
156.1 Carcinoma of liver
IMMEDIATE CAUSE (a) 156.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
2 years | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from March 12, 1956 , to Dec 12, 1967 , that (I) (we) lost saw the deceased alive on Dec 11, 1967 , and that death occurred at 11 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Reinard Gaffe | | 22b. DATE SIGNED
12/13/67 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12-14-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. John's Lutheran | | 23d. LOCATION (City or Town) (County) (State)
Cumberland Co., Penna. | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, | | 25a. REC'D BY REGISTRAR
DEC 19 1967 | |
| ADDRESS
1050 York Road Towson, Md. 21204 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

18583

18583

CHIEF OF BUREAU

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 16583 | | | |
| CERTIFICATE OF DEATH | | | |
| 16575 | | | |
| 1. PLACE OF DEATH
a. COUNTY
<u>Baltimore</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
<u>Md.</u>
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN 1b
<u>30-4</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Shangri-La Nursing Home</u> | | d. STREET ADDRESS
<u>766 Ramsay St.</u> | |
| 3. NAME OF DECEASED
(Type or print)
<u>MATILDA</u> | | 4. DATE OF DEATH
Month <u>12</u> Day <u>11</u> Year <u>1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>Wh</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2/26/86</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years lost birthday)
<u>81</u> yrs. |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Balto., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Ferdinand Koch</u> | | 14. MOTHER'S MAIDEN NAME
<u>Katherine ----</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Miss Minnie Koch</u>
<u>766 Ramsay St. - 212 30</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u>
DUE TO <u>Arteriosclerotic Cardio Vascular Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Arteriosclerotic Cardio Vascular Disease</u>
(c) <u>Disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 10, 1964</u> to <u>Dec 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 11, 1967</u> , and that death occurred at <u>9:20 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Harry L. Knipp</u> | | 22b. DATE SIGNED
<u>12-12-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Harry L. Knipp</u> | | 22d. ADDRESS
<u>4116 Edmondson Ave. Balto, Md 21229</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>12/15/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Western Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Witzke F. D. - 4101 Edmondson Av.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 14 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. [Signature]</u> | |

1858

1858

OFFICE OF THE

DEC 11 1858

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16584

16577

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore #22 | | c. LENGTH OF STAY IN lb
9 Years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
38 Waterview Road (Dundalk) | | d. STREET ADDRESS
38 Waterview Road (Dundalk) | |
| 3. NAME OF DECEASED
(Type or print)
Charles Joseph Kolper | | 4. DATE OF DEATH
Month December Day 17 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 21, 1899 |
| 9. AGE (In years last birthday)
68 yrs. | | IF UNDER 1 YEAR
Months 03 Days 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Superintendent (ret.) | | 10b. KIND OF BUSINESS OR INDUSTRY
Gibbs Packing Co. | |
| 11. BIRTHPLACE (State or foreign country)
Rochester, N.Y. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Kolper | | 14. MOTHER'S MAIDEN NAME
Anna (unknown) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-10-0974 | |
| 17. INFORMANT
Mrs. Julia K. Kolper (wife) | | Address
Same as #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
2043 Acute Leukemia
IMMEDIATE CAUSE (a) 2043
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) | | INTERVAL BETWEEN ONSET AND DEATH
6 mos | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Theodore C. Patterson | | M.D.
Theodore C. Patterson | |
| EXAMINER'S NAME (Type)
Theodore C. Patterson | | M.D.
M.D. | |
| 22. DATE SIGNED
12/19/67 | | Address (Street, city, town, or county)
105 Main St. Dundalk, Md. 21222 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Dec. 20, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
E. B. Fleming | | 25a. REC'D BY REGISTRAR
Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE
DEC 20 1967 | |

18584

Charles J. K. O. S.

E. O. S. 18584

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16585

16578

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Md. 21220 b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bowleys Quarters | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bowleys Quarters 03/1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Box 96, Route 15 | | | | d. STREET ADDRESS 96 (96 Middle Rd.)
Box 96, Route 15 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) | | First WILLIAM Middle KRAISSER Last KRAISSER | | 4. DATE OF DEATH | | Month Dec. 16 Day 19 Year 67 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/10/1904 | | 9. AGE (In years last birthday)
63 yrs. | IF UNDER 1 YEAR
Months 63 Days 0 | IF UNDER 24 HRS.
Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Presser | | 10b. KIND OF BUSINESS OR INDUSTRY
Modern Mfg. | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Fredrick Kraisser | | | | 14. MOTHER'S MAIDEN NAME
Anna Shach | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
216-07-1344 | | 17. INFORMANT
Address Katherine Karas, friend, above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4221 H-S-C-V-Disease DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour 19 e.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE MB Davis
EXAMINER'S NAME (Type) Dr. Melvin B. Davis | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
DATE SIGNED 12-18-67
Address (Street, city, town, or county) 6800 MORNINGTON ROAD 21222 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/19/67 | | 22c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | | 22d. LOCATION (City, town, or country) (State)
Baltimore, Md. | |
| 23. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane | | | | 24a. REC'D BY REGISTRAR
DEC 21 1967 | | 24b. REGISTRAR'S SIGNATURE
J Charles Judge | |

MEDICAL CERTIFICATION

1858

DEC 1 1851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--------------------------------------|---|--|---|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 16586 CERTIFICATE OF DEATH 16579 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>---</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | c. LENGTH OF STAY IN 1b
<u>33</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> <u>2124</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Greater Baltimore Medical Center</u> | | | | | d. STREET ADDRESS
<u>3112 Cedarhurst Ave</u> | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Peter</u> Middle <u>(NNN)</u> Last <u>Kucik</u> Sr. | | | | | 4. DATE OF DEATH
Month <u>12</u> Day <u>5</u> Year <u>1967</u> | | | | |
| 5. SEX
<u>MALE</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>11/24/1911</u> | | 9. AGE (In years last birthday)
<u>56</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Refined Stationary Eng.</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (County & State, or foreign country)
<u>AUSTRIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>George Kucik</u>
<u>XXXXXXXXXXXX</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Amelia</u>
<u>XXXXXXXXXXXX</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>NA</u> | | 16. SOCIAL SECURITY NO.
<u>NA</u> | | 17. INFORMANT
<u>21P-01-89521 - Mrs. Anna Kucik -</u> | | Address
<u>Same</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Corocho-vascular failure,</u>
<u>4201</u>
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. }
(b) <u>Atherosclerotic heart disease, pneumonia</u>
(c) <u>Myocardial infarction</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> , 19 <u>67</u> , to <u>12/5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/5</u> 19 <u>67</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>F. Navidi</u> | | | | | | | | 22b. DATE SIGNED
<u>12/5</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. A. Renick</u> | | | | | 22d. ADDRESS
<u>Greater Balto. Medical Center</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>12/8/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parkwood Cemetery</u> | | | 23d. LOCATION (City, town or county) (State)
<u>Baltimore Co, Maryland</u> | | |
| 24. FUNERAL DIRECTOR
<u>Leonard J. Ruck Inc. 5305 Harford Rd. #</u> | | | | 25a. REC'D BY REGISTRAR
<u>DEC 6 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|-------------------------------------|--|---|---|--------------------------------------|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 16587 | | | | | 16580 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville | | | c. LENGTH OF STAY IN lb
18 Mo. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
College Manor NursingHome | | | | | d. STREET ADDRESS
Dulaney Valley Apts. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) Eva J. Kunkel | | | | | 4. DATE OF DEATH
12-2-1967 | | | | |
| 5. SEX
F | | 6. COLOR OR RACE
Cauc | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6-28-1875 | | 9. AGE (In years last birthday) 92 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Gershom Johnson | | | | | 14. MOTHER'S MAIDEN NAME
Mary K. McCahn | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No. | | | 16. SOCIAL SECURITY NO.
216 09-0567D | | 17. INFORMANT
Mrs Helen Chittick, Towson, Md. 21204 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
4221 IMMEDIATE CAUSE (a) Cerebral thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic cardiovascular disease
DUE TO (c) Neg | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 week |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from January 1964 , to December 1967 , that (I) (we) last saw the deceased alive on September 1967 , and that death occurred at 5:40 P.M. from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
A. Allen Spier | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
12/4/67 | | |
| 22c. PHYSICIAN'S NAME (Type)
A. Allen Spier | | | | | 22d. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL, ETC.
Burial | | 23b. DATE THEREOF
12-5-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks | | | | | 25a. REC'D BY REGISTRAR
DEC 7 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |
| Towson, Md. 21204 | | | | | | | | | |

1822

1822

1000

1000

1000

1822-1823

1822-1823

1822-1823

1822-1823

1822-1823

1822-1823

1822-1823

1822-1823

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16588

CERTIFICATE OF DEATH

16581

| | | | |
|---|---------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>—</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | c. LENGTH OF STAY IN lb
<u>1 day</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Greater Balto. Medical Center</u> | | d. STREET ADDRESS
<u>348 Broadmoor Rd</u> | |
| 3. NAME OF DECEASED
(Type or print)
<u>Tina H. Kuciala</u> | | 4. DATE OF DEATH
Month <u>12</u> Day <u>24</u> Year <u>1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>CAU.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>4-7-82</u> |
| 9. AGE (In years last birthday)
<u>85</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE - OWN HOME</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Alois NMW Hanzlik</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARIEMACHNEK</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>N/A</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>unknown</u> | |
| 17. INFORMANT
<u>Pt's. chart</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4221</u> IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u>
DUE TO
(b) <u>Arterio-sclerotic cardiovascular disease</u>
DUE TO
(c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>DEHYDRATION & ELECTROLYTE IMBALANCE</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>—</u> o.m. <u>—</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/23</u> , 19 <u>67</u> , to <u>12/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> , 19 <u>67</u> , and that death occurred at <u>8:35 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Dech A Bruce</u> | | 22b. DATE SIGNED
<u>12/24/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>DR. EIL A. B KUCIALA</u> | | 22d. ADDRESS
<u>G. B. A. C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>12/28/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Oaklawn</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore County, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>H.W. Jenkins & Sons Co.</u> | | 25a. REC'D BY REGISTRAR
<u>DEC 27 1967</u> | |
| ADDRESS
<u>4905 York Rd. Balto. 12, Md.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16589

M

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16582

| | | | | | |
|---|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reisterstown | | c. LENGTH OF STAY IN 1b
28 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reisterstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
23 Hanover Road | | | d. STREET ADDRESS
23 Hanover Road | | |
| 3. NAME OF DECEASED (Type or print)
First Annie Middle Silex Last Landau | | | 4. DATE OF DEATH
Month December Day 28 Year 19 67 | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
January 3, 1895 | 9. AGE (In years last birthday)
72 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
--- | | 11. BIRTHPLACE (County & State, or foreign country)
Stettin, Germany | |
| 13. FATHER'S NAME
Heinrich Silex | | | 14. MOTHER'S MAIDEN NAME
Anna Hennig | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-54-3013 | | 17. INFORMANT
23 Hanover Rd., Reisterstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Acute coronary occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic cardio-vascular disease
DUE TO at once
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Mar 16, 1962 to Dec. 28, 1967 that (I) (we) last saw the deceased alive on Dec. 28, 1967 and that death occurred at 4:15 P.M. from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
S. Walter Landau | | M.D.
S. Walter Landau | | 22b. DATE
12-27-67 | |
| 22c. PHYSICIAN'S NAME (Type)
S. Walter Landau | | 22d. ADDRESS
23 Hanover Rd., Reisterstown | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Dec. 30, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Mem. Gardens Finksburg, Maryland | |
| 23d. LOCATION (City, town or county) | | 23e. (State) | | 23f. (Country) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
H. J. Schardt | | ADDRESS
Owings Mills, Md. | | 25a. REC'D BY REGISTRAR
JAN 2 1968 | |
| 25b. REGISTRAR'S SIGNATURE
J. J. Judge | | 25c. DATE | | | |

VR A15 (4)
15M 9/60

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1888

Baltimore

Johnston

23 Hanover Road

Anna

Female White

Henrietta

Helmut Alex

No

Baltimore

Johnston

23 Hanover Road

Anna

Female White

Henrietta

Helmut Alex

23 Hanover Road, Baltimore, Md.

that is very old

that is very old

Dec. 30, 1907, Baltimore, Maryland

H. J. Elliott, Baltimore, Md.

Dec. 30, 1907
Baltimore, Md.
H. J. Elliott

Dec. 30, 1907
Baltimore, Md.
H. J. Elliott

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | |
|---|---|---|--|--|---|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | |
| 16590 | | | CERTIFICATE OF DEATH | | |
| 16583 | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Essex</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Ivy Hall Nursing Home</u> | | | d. STREET ADDRESS
<u>1420 Shore Road</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First <u>Katherine</u> Middle <u>E.</u> Last <u>Long</u> | | | 4. DATE OF DEATH
Month <u>December</u> Day <u>31</u> Year <u>1967</u> | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 7, 1887</u> | 9. AGE (In years last birthday)
<u>80</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | |
| 13. FATHER'S NAME
<u>Gustav Walter</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Marie ?</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Mr. Frederick Boerschel</u> Address <u>1700 Meridene Dr. 21212</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic Myocardial Failure</u>
DUE TO <u>Arteriosclerotic Cardiovascular</u>
DUE TO <u>Disease & Hypertension</u>
(c) <u> </u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 10</u> , 19 <u>67</u> , to <u>Dec 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 30</u> , 19 <u>67</u> , and that death occurred at <u>104</u> M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>[Signature]</u> | | | 22b. DATE SIGNED
<u>12/31/67</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>[Signature]</u> | | | 22d. ADDRESS
<u>Balto 21237</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>1/4/68.</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> | | |
| 24. FUNERAL DIRECTOR
<u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | | | 25a. RECEIVED BY REGISTRAR
DATE <u>JAN 2 1968</u> | | |
| | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

A3C
4/19/68

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|---|--|--|--|--|--|--|--|---|--|--|--|---|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|---|--|--------------------------------|--|--|--|
| 16591 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 16584 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON
c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. JOSEPH HOSPITAL | | | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 3203 JOPPA ROAD #21234
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First MARTHA Middle EUGENIA Last LANG | | | | | | 4. DATE OF DEATH DECEMBER 27 1967 | | | | | | 5. SEX FEMALE | | | | | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH APRIL 20, 1899 | | | | 9. AGE (In years lost birthday) 68 yrs. | | | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | | 11. BIRTHPLACE (County & State, or foreign country) BALTIMORE COUNTY, MD. | | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME Wilfred H. Fuller | | | | | | 14. MOTHER'S MAIDEN NAME Rosie L. Dent | | | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | | | 16. SOCIAL SECURITY NO. 215-07-0535 | | 17. INFORMANT Mr. Howard Fuller Address (Same) | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
260x IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DIABETES MELLITUS
DUE TO
(c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from DECEMBER 27, 1967 , to DECEMBER 27 19 67 that (I) (we) last saw the deceased alive on DECEMBER 27 19 67 , and that death occurred at 11:10 PM from causes and on the date stated above. | | | | | | | | | | | | 22a. SIGNATURE ISMAEL JAMORA, M. D.
M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | | | 22b. DATE SIGNED DECEMBER 27, 1967 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | 23b. DATE THEREOF 12/30/67. | | 23c. NAME OF CEMETERY OR CREMATORY Hiss Methodist Cemetery | | | | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | | | 25a. REC'D BY REGISTRAR DEC 28 1967 | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | | | | | | | | | | | | | |

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DEPARTMENT OF DEFENSE

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OFFICE OF THE SECRETARY

WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on this funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|----------------------------------|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 16592 | | CERTIFICATE OF DEATH | |
| 16585 | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TOWSON | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TOWSON | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
149 STEVENSON LANE | | d. STREET ADDRESS
149 STEVENSON LANE | |
| 3. NAME OF DECEASED
(Type or print)
WILLIAM E LEUTNER | | 4. DATE OF DEATH
Month DECEMBER Day 19 Year 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
SEPT. 17, 1898 |
| 9. AGE (In years last birthday) yrs. 69 | | IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY
CLERK | |
| 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HENRY LEUTNER | | 14. MOTHER'S MAIDEN NAME
ELIZABETH HERION | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
216-07-1460 A | |
| 17. INFORMANT
MRS. ELEANOR JOHNSON | | Address
SAME | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4500
IMMEDIATE CAUSE (a) Acute Cardiac Failure
DUE TO
(b) Arteriosclerosis
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 20, 1960 , to Dec. 19, 1967 , that (I) (we) last saw the deceased alive on Dec. 19, 1967 , and that death occurred at 4:4 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Lawrence C. Post | | 22b. DATE SIGNED
12/20/67 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. LAWRENCE C. POST | | 22d. ADDRESS
6805 YORK RD. BALTIMORE, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12-20-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
DULANEY VALLEY | | 23d. LOCATION (City or Town) (County) (State)
TIMONIUM, MARYLAND | |
| 24. FUNERAL DIRECTOR
MITCHELL WIEDEFELD HOME, INC.
6500 YORK ROAD BALTIMORE, MD. 21212 | | 25a. REC'D BY REGISTRAR
DATE 12/20/67 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

18252

10285

BALTIMORE

MARYLAND

BALTIMORE

TOWSON

TOWSON

145 STEVENSON PARK

145 STEVENSON PARK

WILLIAM F. TOWSON

DECEMBER 1, 1964

WHITE

SEP. 17, 1968

RECEIVED

CLARK

BALTIMORE, MARYLAND, U.S.A.

HERBERT L. TOWSON

ELIZABETH MERRILL

NO

316-01-1000 A. MRS. ELIZABETH MERRILL

12-28-67

MURPHY VALLEY

BALTIMORE, MARYLAND

6500 YORK ROAD BALTIMORE, MD. 21212

DR. LAWRENCE C. TOWSON

6002 YORK RD. BALTIMORE, MD.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16593

16586

FOR STATE
HEALTH DEPT.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland b. COUNTY
BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Woodlawn | | c. LENGTH OF STAY IN lb
Woodlawn | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
3410 JoAnn Drive D.O.A. | | d. STREET ADDRESS
3410 JoAnn Drive | |
| 3. NAME OF DECEASED
(Type or print)
HAROLD A. LEV | | 4. DATE OF DEATH
Month December Day 3 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JUNE 26, 1928 |
| 9. AGE (In years last birthday)
39 yrs. | | 10. IF UNDER 1 YEAR
Months 03 Days 1 IF UNDER 24 HRS.
Hours 03 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ATTORNEY | | 10b. KIND OF BUSINESS OR INDUSTRY
AT LAW | |
| 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CARL LEV | | 14. MOTHER'S MAIDEN NAME
GUSSIE BUTENSKY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MRS. PHYLLIS LEV, 3410 JOANN DRIVE #21207 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
976X IMMEDIATE CAUSE (a) Gunshot wound of the head
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Subject shot himself | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
Pro. 6 xxx 12 3 1967 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | 20f. (City or town) (County) (State)
Woodlawn Balto. Md. |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Edward F. Wilson M.D. | | 22. DATE SIGNED
December 3, 1967 | |
| EXAMINER'S NAME (Type)
Edward F. Wilson, M.D. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
12-4-67 | 23c. NAME OF CEMETERY OR CREMATORY
BETH EL MEMORIAL PARK | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD | | 25a. REC'D BY REGISTRAR
DEC 5 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1859

1859

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

JUNE 28, 1859

WILLIAM

ATTORNEY

AT LAW

BALTIMORE, MARYLAND

CARL LEV

MISSIE BUTLER

NO

Continued from the previous page

Subject of the case

Continued

[Handwritten signature]

Witness: J. H. H. H.

WILLIAM

17-1-17

WILLIAM

1859

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and direct, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 16594 | | | | | CERTIFICATE OF DEATH | | | 16587 | |
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>BALTO</i> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Towson</i> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Baltimore</i> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Chesapeake Manor Nursing Home</i> | | | | | d. STREET ADDRESS
<i>9850 Harford Road</i> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <i>Robert</i> First <i>D.</i> Middle <i>Lisle</i> Last | | | | | 4. DATE OF DEATH
Month <i>December</i> Day <i>25</i> Year <i>1967</i> | | | | |
| 5. SEX
<i>Male</i> | | 6. COLOR OR RACE
<i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>July 23, 1877</i> | | 9. AGE (In years last birthday) <i>90</i> yrs. | |
| | | | | | | | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired from Western Maryland Dairy</i> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Maryland Dairy</i> | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Reisterstown</i> | | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>John D. Lisle</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Annie Crawford</i> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<i>No</i> | | | 16. SOCIAL SECURITY NO.
<i>216-45-8108</i> | | 17. INFORMANT
Address <i>Mrs. Emmitt Power 9850 Harford Rd. Balto. Md.</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinoma Rectum c</i>
DUE TO <i>metastasis</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Generalized Cachexia.</i>
(b) <i>Generalized Cachexia.</i>
(c) <i>Generalized Cachexia.</i> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 yr. + 4 mos.</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
<i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> , 19 <i>67</i> , to <i>Dec</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Dec 20</i> , 19 <i>67</i> , and that death occurred at <i>11:26</i> M, from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<i>Frank J. Kasik</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<i>12/26/67</i> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<i>F.T. KASIK JR</i> | | | | 22d. ADDRESS
<i>9005 HARFORD RD</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Buried</i> | | | 23b. DATE THEREOF
<i>Dec. 28, 67</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Lutheran Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Reisterstown, Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>J. F. Eline & Sons</i> | | | | | ADDRESS
<i>Reisterstown, Md.</i> | | 25a. REC'D BY REGISTRAR
DATE <i>DEC 28 1967</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> |

1850

REPORT OF DEATH

1850

Generalized Cachexia
metastatic
Carcinoma of the
Prostate

Wm. H. Jones
F.T. KASK TR

Dec 20 1850
door removed

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

16595

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16588

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Pennsylvania</u> b. COUNTY <u>BALTO.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | c. LENGTH OF STAY IN 1b
<u>D.O.A.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>St. Joseph's Hospital</u> | | d. STREET ADDRESS
<u>10313 Malcolm Circle</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Nellie</u> | | 4. DATE OF DEATH
Month <u>December</u> Day <u>22</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>April 12, 1886</u> | |
| 9. AGE (In years last birthday) yrs. <u>81</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Thomas G. Russell</u> | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Sutton</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | |
| 17. INFORMANT
<u>Family records</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
<u>4201</u>
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
DUE TO (b) <u>Hypertensive Atherosclerotic</u>
DUE TO (c) <u>Cerebral Vascular Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>Charles F. O'Donnell</u>
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u> | | 22. DATE SIGNED
<u>1-23-67</u> | |
| 23a. BURIAL, CREMATION, REMOVAL <u>Burial</u> | | 23b. DATE THEREOF
<u>Dec. 26, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Woodlawn Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Pittsville, Pennsylvania</u> | |
| 24. FUNERAL DIRECTOR
<u>John Burns' Sons, Towson, Maryland</u> | | 25a. REC'D BY REGISTRAR
<u>DEC 27 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--------------------------------------|--|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 16596 Item #2b,c & d Film #G396 12/20/67 ph | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 16589 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Towson
c. LENGTH OF STAY IN 1b
30.4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Greater Baltimore Medical Center | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
2902 Berwick Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Clarence Edward Lohran | | | | | | 4. DATE OF DEATH
Month Day Year
12 7 19 67 | | | | | |
| 5. SEX
M | | 6. COLOR OR RACE
Cau | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5/5/04 | | 9. AGE (In years lost birthday)
63 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Accountant | | | | 10b. KIND OF BUSINESS OR INDUSTRY
General Electric Co. | | | | 11. BIRTHPLACE (County & State, or foreign country)
Hungary | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Peter Lohran | | | | | | 14. MOTHER'S MAIDEN NAME
Marie Buocz | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
215-09-8723 | | 17. INFORMANT
Address
Mr. Vincent M. Lohran 134 N. Luzerne Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Carcinoma of lung
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | | | |
| 20c. TIME OF INJURY
Hour a.m. Month, Day, Year
p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 2 , 19 67 , to Dec. 7, 1967 , that (I) (we) last saw the deceased alive on Dec. 6 , 19 67 , and that death occurred at 7:30 AM , from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
John E. Adams | | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
12/7/67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
John E. Adams, M.D. | | | | | | 22d. ADDRESS
6701 N. Charles Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/11/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
John A. Moran, Inc. 3000 E. Baltimore St. | | | | | | 25a. REC'D BY REGISTRAR
DEC 11 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] | | | |

16589

16589

STATE OF OHIO

John E. Adams

16589

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

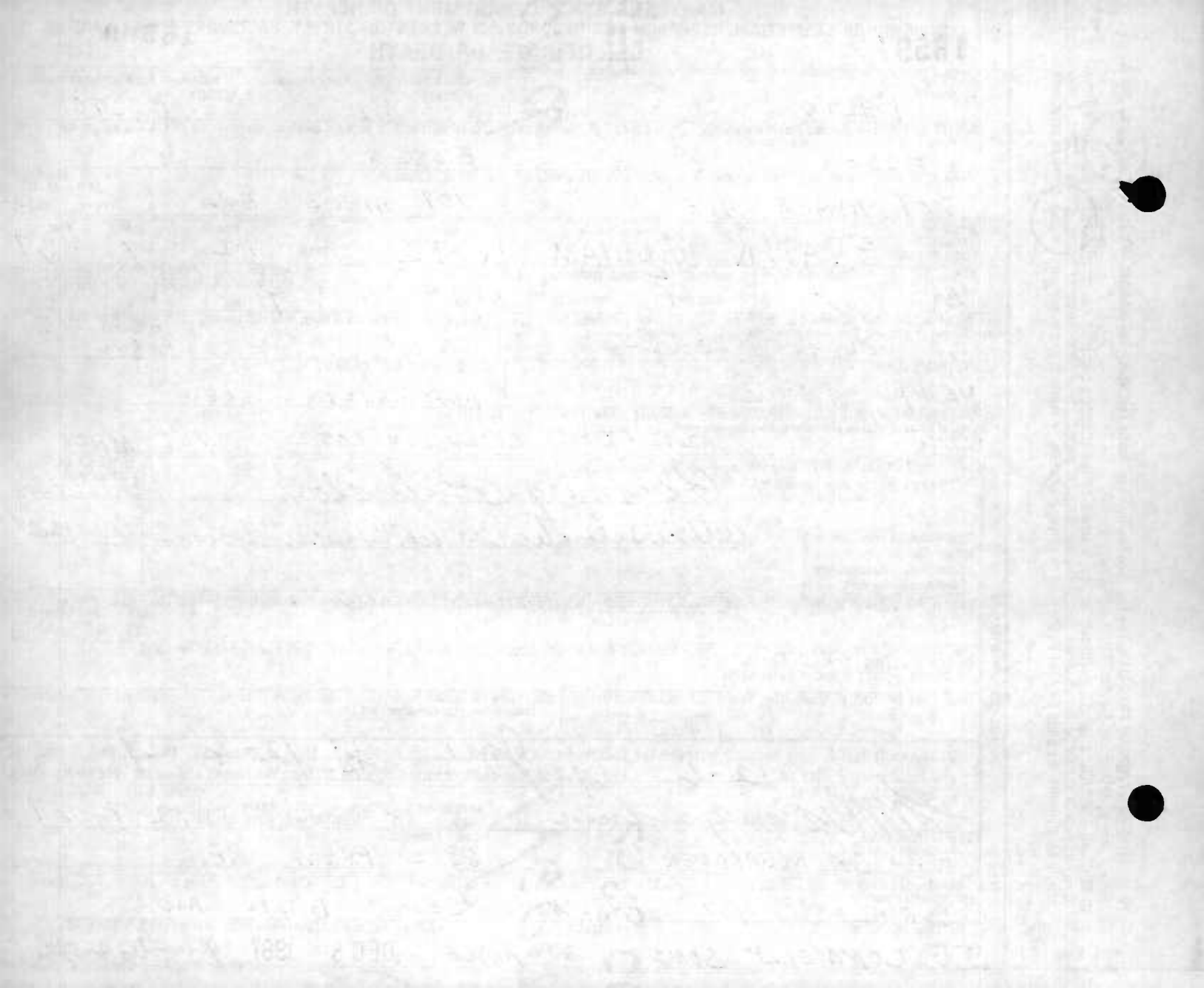
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

16597

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16597
CERTIFICATE OF DEATH

| | | | |
|---|------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTO MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE MD. b. COUNTY BALTO. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ESSEX | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ESSEX | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
701 MACE AVE | | d. STREET ADDRESS
701 MACE AVE | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First FRANK Middle WILLIAM Last LOTZ | | 4. DATE OF DEATH
Month 12 Day 7 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
NOV. 9, 1896 |
| 9. AGE (In years last birthday)
71 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CLERK | | 10b. KIND OF BUSINESS OR INDUSTRY
COUNTY | |
| 11. BIRTHPLACE (County & State, or foreign country)
MD. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
HENRY LOTZ | | 14. MOTHER'S MAIDEN NAME
MARGARET MILLER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
UNK | | 16. SOCIAL SECURITY NO.
2 12-07-6153 | |
| 17. INFORMANT
ELIZABETH LOTZ | | Address
701 MACE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,
DUE TO (b) Arteriosclerotic Cardiovascular disease
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
2 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1967 to 12-6, 1967 , that (I) (we) last saw the deceased alive on 12-6, 1967 , and that death occurred at 5A M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Sam Baumgardner | | 22b. DATE SIGNED
12-7-67 | |
| 22c. PHYSICIAN'S NAME (Type)
D.M. BAUMGARDNER | | 22d. ADDRESS
8552 PHILA. RP. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12/9/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
PARKWOOD CEM | | 23d. LOCATION (City, town or county) (State)
BALTO. MD. | |
| 24. FUNERAL DIRECTOR
J.G. CONNELLY SONS | | 25a. REC'D BY REGISTRAR
DEC 8 1967 | |
| ADDRESS
300 MACE | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 16598 | | 16591 | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY MARYLAND
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS 12311 BRAXFIELD COURT | |
| 3. NAME OF DECEASED (Type or print)
First NAPOLEON Middle LOVELY Last LOVELY | | 4. DATE OF DEATH
Month DECEMBER 2 Day 19 Year 67 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9 15 07 |
| 9. AGE (In years last birthday) 60 yrs. | | 10. IF UNDER 1 YEAR
Months 60 Days 00 Hours 00 Min. 00 | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERGYMAN | | 11b. KIND OF BUSINESS OR INDUSTRY CLERGYMAN | |
| 12. BIRTHPLACE (County & State, or foreign country) NORTH KINGSTON, RHODE ISLAND | | 13. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14. FATHER'S NAME JOSEPH LOVELY | | 15. MOTHER'S MAIDEN NAME ANN WIGLESWORTH | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 17. SOCIAL SECURITY NO. WW-11 | |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES | | 19. ADDRESS CLIN. REC., VAH, FORT HOWARD, MARYLAND | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA, ASPIRATION
DUE TO CHRONIC BRAIN SYNDROME
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. 304x
(b) CHRONIC BRAIN SYNDROME
DUE TO CHRONIC BRAIN SYNDROME
(c) CHRONIC BRAIN SYNDROME | | INTERVAL BETWEEN ONSET AND DEATH DAYS
MONTHS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 16, 19 67 to Dec. 2, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 2, 19 67 , and that death occurred at 12:15a M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Jorge A. Fabara | | 22b. DATE SIGNED 12 2 67 | |
| 22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D. | | 22d. ADDRESS VET. ADM. HOSP., FT. HOWARD, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/5/67 | 23c. NAME OF CEMETERY OR CREMATORY ELM GROVE CEMETERY | 23d. LOCATION (City or Town) (County) (State) NO. KINGSTON, RHODE ISLAND |
| 24. FUNERAL DIRECTOR John J. Duda, Dundalk, Md. | | 25a. REC'D BY REGISTRAR GEO. C. CRANSTON
WICKFORD, R. I. | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

WICKHED, R. I. 1923
 GEO. C. CHASTON
 ELM GROVE CEMETERY
 NO. KINGSTON, RATES ISLAND

JORGE A. BARBARA, M. D. VST. ADM. HOSP., FT. HOWARD, MD.

X 12 2 07

Dec. 2, 07

August 10 12:12A

Dec. 2

X 07

CHRONIC BRAIN SYNDROME

MONTHS

PNEUMONIA, ASPIRATION

DAYS

YES

WM-11

460 42 2750

CLIN. REC.

WAL

PORT HOWARD

PORT HOWARD

ALL WTS. 140 LBS.

CLASSIC

MALE

WHITE

MAPOLETON

LOVELLY

DECEMBER 2

VETERANS ADMINISTRATION HOSPITAL

12311 BRAXFIELD COURT

104 DAYS

ROCKVILLE

BALTIMORE

MARYLAND

PORT HOWARD

1652

CERTIFICATE OF DEATH

16599

16592

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY HARFORD | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN lb
53 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS
329 MC CANN STREET | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle GEORGE Last LOWE, JR. | | 4. DATE OF DEATH
Month DECEMBER Day 18 Year 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JULY 6, 1915 |
| 9. AGE (In years lost birthday)
52 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY
EDGEWOOD ARSENAL | |
| 11. BIRTHPLACE (County & State, or foreign country)
STREET, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN/LOWE, SR. | | 14. MOTHER'S MAIDEN NAME
AGNAS A. MARTIN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW II | | 16. SOCIAL SECURITY NO.
215 14 53 88 | |
| 17. INFORMANT
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) TUBERCULOUS MENINGITIS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MILIARY TUBERCULOSIS
DUE TO
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
BRONCHOGENIC CARCINOMA WITH ADRENAL METASTASIS AND BRONCHOPNEUMONIA | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from 10/26/67 , 19__, to 12/18/67 , 19__, that (2) (we) last saw the deceased alive on 12/18/67 , 19__, and that death occurred at 3:00 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>John D. Talbert</i> | | 22b. DATE SIGNED
12/19/67 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M. D. | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Dec. 21, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
BEL AIR MEMORIAL GARDENS | | 23d. LOCATION (City or Town) (County) (State)
BEL AIR, MARYLAND | |
| 24. FUNERAL DIRECTOR
HOWARD K. | | 25a. REC'D BY REGISTRAR
MC COMAS FUNERAL HOME
25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i>
DATE DEC 21 1967
ABINGDON, MARYLAND | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1851

CERTIFICATE OF DEATH

1852

DEATH

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

16600

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16593

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
30yr7mth20dys | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | d. STREET ADDRESS
3913 East Pratt Street | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Anna | | 4. DATE OF DEATH
Month December Day 8 Year 1967 | |
| 5. SEX
female | | 6. COLOR OR RACE
white | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 27, 1907 | |
| 9. AGE (In years and months)
60 yrs. | | 10. IF UNDER 1 YEAR
Months 6 Days 10 Hours 10 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Italy | | 12. CITIZEN OF WHAT COUNTRY?
Italy <input checked="" type="checkbox"/> | |
| 13. FATHER'S NAME
John Frasco | | 14. MOTHER'S MAIDEN NAME
Josephine Attina | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO
(b) Arteriosclerotic, Cardiovascular Ht. Dis.
DUE TO
(c) Arteriosclerosis, Generalized, Senile | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 230/100
Diabetes Mellitus (20yrs.), Obesity (300 lbs.), Hypertension | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 1, 1967 , to Dec. 8, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 8, 1967 , and that death occurred at 8:30 A.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Anthony J. Young, M.D. | | 22b. DATE SIGNED
12-8-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/11/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
HENRY SANDER & SONS INC. | | 25a. REC'D BY REGISTRAR
DEC 12 1967 | |
| ADDRESS
BALTIMORE MARYLAND 21213 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

VR A15 (4)
25M 1/67

434
4/18/68

18800

18800

18800

18800

18800

18800

18800

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|------------------------------|--|---|---|---|---|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 16601 | | | | | 16594 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
BALTIMORE | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE
MARYLAND | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
RURAL, BALTIMORE | | | | | b. COUNTY
BALTIMORE | | | | | | | | | |
| c. LENGTH OF STAY IN 1b
9 YR | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
RURAL, BALTIMORE | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
8605 CHESTNUT OAK RD | | | | | d. STREET ADDRESS
8605 CHESTNUT OAK RD. | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
JEANETTE IRENE MACKLEY | | | | | 4. DATE OF DEATH
Month Day Year
DECEMBER 5 1967 | | | | | | | | | |
| 5. SEX
F | | 6. COLOR OR RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
DEC 29 1913 | | 9. AGE (In years last birthday)
53 yrs. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PERSONNEL SUPERVISOR | | | | 10b. KIND OF BUSINESS OR INDUSTRY
DEPT. STORE | | 11. BIRTHPLACE (County & State, or foreign country)
ADAMS CO. PENNA. | | 12. CITIZEN OF WHAT COUNTRY?
USA. | | | | | | |
| 13. FATHER'S NAME
ROBERT K. WEAVER | | | | | 14. MOTHER'S MAIDEN NAME
NORWAY TRIMMER | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | | | 16. SOCIAL SECURITY NO.
1 PD-109450 | | 17. INFORMANT
Address
HUSBAND ABOVE. | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 154X CARCINOMA OF RECTUM METASTASES
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
7 MO. | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from MAY, 1967, to DEC 5, 1967, that (I) (we) last saw the deceased alive on DEC. 1 1967, and that death occurred at 10:50 PM, from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE
Samuel I. O'Mansky | | | | | 22b. DATE SIGNED
DEC 5 67 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
SAMUEL I. O'MANSKY | | | | | 22d. ADDRESS
8523 LOCHRAVEN BLVD. BALTO. 4. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 23b. DATE THEREOF
12/6/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Prospect Hill Cemetery | | | 23d. LOCATION (City, town or county) (State)
York, Pa. Manchester Township | | | | | | | |
| 24. FUNERAL DIRECTOR
Wm. J. Tubman Sons | | | | | 25a. REC'D BY REGISTRAR
DEC 8 1967 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

1880

DEPARTMENT OF STATE

1880

Proclamation No. 1111
January 11, 1880
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|--|---|---|--|--|---|---|---|---|--|
| 16602 | | | | | 16595 | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural - Towson
c. LENGTH OF STAY IN 1b
1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Greater Baltimore Medical Center | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Towson
d. STREET ADDRESS
32 Dunvale Road
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Kathryn Elizabeth Manley | | | 4. DATE OF DEATH
12 6 1967 | | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 8, 1896 | | 9. AGE (In years last birthday)
71 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (County & State, or foreign country)
Illinois | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Patrick L. Holden | | | | | 14. MOTHER'S MAIDEN NAME
Kathryn Sheedy | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Family records | | Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant hypertension with uremia
442X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant nephrosclerosis
DUE TO (c) Hypertensive cardiovascular disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/5 , 19 67 , to 12/6 , 19 67 , that (I) (we) last saw the deceased alive on 12/6 , 19 67 , and that death occurred at 5:25M , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
John E. Adams | | | | | am
M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED
12/6/67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
John E. Adams, M.D. | | | | | 22d. ADDRESS
6701 N. Charles Street | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
December 9, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Cemetery | | | 23d. LOCATION (City, town or county) (State)
Cockeysville, Maryland | | | | |
| 24. FUNERAL DIRECTOR
John J. Burns Sons | | | | | ADDRESS
Towson Md. | | 25a. REC'D BY REGISTRAR
DEC 11 1967 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | |

1860

1861-1862-1863

DAVID MINTZ

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16603

CERTIFICATE OF DEATH

16596

| | | | | | | | |
|--|--|--|-------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lutherville, 21093</u> 03-1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>St. Joseph Hospital</u> | | | | d. STREET ADDRESS
<u>1101 Longbrook Rd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Edgar</u> Middle <u>Flavius</u> Last <u>Martin</u> | | | | 4. DATE OF DEATH
Month <u>December</u> Day <u>21</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>August 16, 1901</u> 66 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>retired Exec. Sec.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Y.M.C.A.</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Mississippi</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Wesley A. Martin</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Ella Ward</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> <u>none</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Family records</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Myocardial infarction</u>
DUE TO
(c) <u>Coronary arteriosclerosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>Dec. 16</u> , 19 <u>67</u> , to <u>Dec. 21</u> , 19 <u>67</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>Dec. 21</u> 19 <u>67</u> , and that death occurred at <u>12:55 AM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Ines Cilliant</u> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>12/21/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Ines Cilliant, M.D.</u> | | | | 22d. ADDRESS
<u>7620 York Rd., Towson, Md. 21204</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Dec. 23, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Chestnut Grove Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Jacksonville, Balto. Co., Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>John Burns' Sons, Towson, Maryland</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 26 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. [Signature]</u> | |

10530

RECEIVED BY MAIL

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RECEIVED BY MAIL
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 16597 | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore Co.
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Hydes
c. LENGTH OF STAY IN 1b
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hydes
d. STREET ADDRESS
Patterson Rd.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Clara W. Masland | | | | | | 4. DATE OF DEATH
Month Day Year
December 14 1967 | | | | | | | |
| 5. SEX
F | | 6. COLOR OR RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8/30/1895 | | 9. AGE (In years last birthday)
72 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Teacher | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Musician | | | | 11. BIRTHPLACE (County & State, or foreign country)
Boston, Mass. V | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Obidiah Firth Wells | | | | | | 14. MOTHER'S MAIDEN NAME
Helen Deeds | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
525-26-3389A | | | | 17. INFORMANT
Mr. Samuel Nasland Patterson Rd Hydes, Md.
Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant lymphoma
200.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis
INTERVAL BETWEEN ONSET AND DEATH 6 months | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from January 1960 to December 14, 1967 , that (I) (we) last saw the deceased alive on December 8, 1967 , and that death occurred at 10 P.M. from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
Richard N. Tillman
M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED
December 17, 1967 | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Richard N. Tillman | | | | | | 22d. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE THEREOF
12/18/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Crematory | | | | 23d. LOCATION (City, town or county) (State)
Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. J. Tickner & Sons Balto., Md.
ADDRESS | | | | | | 25a. RECEIVED BY REGISTRAR
DEC 21 1967
DATE | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 16605 | | 16598 | |
| CERTIFICATE OF DEATH | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALT. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | c. LENGTH OF STAY IN lb
4 mo. 8 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSP | | d. STREET ADDRESS
5903 CECIL AVE | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
First ALONZO Middle M. Last MATHIAS | | 4. DATE OF DEATH
Month DEC Day 10 Year 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-22-1893 |
| 9. AGE (In years last birthday)
74 yrs. | | IF UNDER 1 YEAR
Months 10 Days 10 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
GAS & ELEC. Co. | 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
William Mathias | |
| 14. MOTHER'S MAIDEN NAME
Amelia Horton | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO.
220-01-2489 | | 17. INFORMANT
Mrs. Barbara Mathias Address 5903 Cecil Ave 21207 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic cardio-vascular disease
DUE TO
(c) Generalized - Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that it (this hospital) attended the deceased from AUG 2, 1967 , to DEC 10, 1967 , that it (we) last saw the deceased alive on Dec. 10, 1967 , and that death occurred at 3:12 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Olive Reid Harris MD | | 22b. DATE SIGNED
12-10-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Olive Reid Harris | | 22d. ADDRESS
SPRING GROVE | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
12-13-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | 23d. LOCATION (City or Town) (County) (State)
Woodlawn, Maryland |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. | | 25a. REC'D BY REGISTRAR
DEC 12 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

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| 1. PLACE OF DEATH
a. COUNTY
BALTIMORE | | 21222 | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
b. STATE
MARYLAND | | b. COUNTY
BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
DUNDALK | | c. LENGTH OF STAY IN lb
50 YRS. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
DUNDALK | | d. STREET ADDRESS
55 NORTHSHIP ROAD | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
55 NORTHSHIP ROAD | | | | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
RALPH FRANKLIN MATTOX | | First | | Middle | | Last | | 4. DATE OF DEATH
26 DECEMBER, 1967 | |
| 5. SEX
MALE | | 6. COLOR OR RACE
CAUCASIAN | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
21 SEPT. 1898 | | 9. AGE (In years last birthday)
69 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
GENL. YARD MASTER | | 10b. KIND OF BUSINESS OR INDUSTRY
RAILROAD | | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY?
USA | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 13. FATHER'S NAME
CHARLES W. MATTOX | | 14. MOTHER'S MAIDEN NAME
IDA BELLE KERR | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
705/10/9446 | | 17. INFORMANT
INA B. MATTOX-WIDOW- | | Address
AS IN # 2 ABOVE | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) A-S-C-V-Disease
DUE TO
(c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 Min | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
None | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
M. B. Davis | | | | | | | | | |
| ACTUAL SIGNATURE
M. B. Davis | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED
12/28/67 | | | |
| EXAMINER'S NAME (Type)
MELVIN B. DAVIS, MD. DUNDALK | | | | Address (Street, city, town, or county)
6800 HORNINGTON RD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
29/12/1967 | | 23c. NAME OF CEMETERY OR CREMATORY
MEADOWRIDGE | | 23d. LOCATION (City, town or county) (State)
DORSEY, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
WALTER BROOKS BRADLEY, DUNDALK, MD. | | | | 25a. REC'D BY REGISTRAR
DEC 29 1967 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16607

CERTIFICATE OF DEATH

16600

| | | | | | | | |
|---|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | | | d. STREET ADDRESS
1508 Northgate Rd., 21218 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) LAURA L. McCorquindale | | | | 4. DATE OF DEATH
Month December Day 18 Year 1967 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/22/01 | | 9. AGE (In years last birthday)
66 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Texas | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
? DOBBYN | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
hospital records Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic coma
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) portal cirrhosis
DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that the (this hospital) attended the deceased from Dec. 11, 19 67 , to Dec. 18, 19 67 , that it (we) last saw the deceased alive on Dec. 18, 19 67 , and that death occurred at 5:45 M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
William | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
12/19/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Ines Cilliani, M.D. | | | | 22d. ADDRESS
7620 York Rd., Towson, Md., 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12/21/67 | | 23c. NAME OF CEMETERY OR CREMATORY
MCAELAND | | 23d. LOCATION (City or Town) (County) (State)
BALTO. MD. | |
| 24. FUNERAL DIRECTOR
E. S. MACNAB | | | | ADDRESS
301 FREDERICK RD 21228 | | 25a. REC'D BY REGISTRAR
DEC 27 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

MEDICAL CERTIFICATION

1880

RECEIVED

1880



UNITED STATES
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ZDM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16603
16602
16602
CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Balto.
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House In The Pines | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS E 133 S. Augusta Ave.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Alice Middle E. Last McCusker | | 4. DATE OF DEATH
Month Dec. Day 7, Year 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 31, 1887 |
| 9. AGE (In years last birthday) 80 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Annapolis Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John J. McCusker | | 14. MOTHER'S MAIDEN NAME Alice Walton | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Balto. Md. Address 21229 | | Miss. Corine A. McCusker 133 S. Augusta Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ATHEROSCLEROTIC CV Heart Disease
4221
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1 EMBOLIC ARTERIAL GANGRENE 2 Cong 2 C.U.A. | | | INTERVAL BETWEEN ONSET AND DEATH 3 YRS |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 9-12, 1956 , to 12-7, 1967 , that (I) (we) last saw the deceased alive on 12-7 1967 , and that death occurred at 3 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John F. Schaefer | | 22b. DATE SIGNED 12/8/67 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER MD | | 22d. ADDRESS 4401 RANDOM RD. - 21229 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec. 9, 1967 | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | 23d. LOCATION (City, town or county) (State) Balto. Md. |
| 24. FUNERAL DIRECTOR G. Truman Schwab | | 25a. REC'D BY REGISTRAR DEC 11 1967 | |
| ADDRESS 3512 Frederick Ave. Balto. Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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Journal of the American Medical Association

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• *Journal of Management Education* •

• *revelation* • *truth* •

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• C. I. D.

• **not** **intended** **to** **kill**

1961, 1962

Lévesque

D. Freeman Johnson 3512 Frederick Ave. Balto. Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16609

16603

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) XXXXX Edley H. McDonald, Sr. | | | 2a. DATE OF DEATH
Month Day Year
December 28 1967 | | | 2b. HOUR
M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
9-29-1890 | | 6. AGE (In years last birthday)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Hume, W. Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Woodlawn | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
6902 Windsor Mill Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
6902 Windsor Mill Road | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
NO | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Annie McDonald-6902 Windsor Mill Road | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intractable Congestive Heart Failure</u>
4221
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>severe Aortic Insufficiency</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ASCVD</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Senility - Cerebral Artery Insufficiency</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-6-</u> , 19 <u>66</u> , to <u>12-28, 1967</u> , that (I) (we) last saw the deceased alive on <u>12-28-1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Cesar Valle Cervero</u> | | | | DEGREE ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12-29-67</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
CESAR VALLE CAVERO | | | | 22e. ADDRESS
<u>8629 Liberty Rd</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1-2-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
Ellsworth Armacost-4600 Liberty Hghts. Ave | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
JAN 3 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

10822

10822

10822

[Faint, mostly illegible text spanning the main body of the page, possibly bleed-through from the reverse side.]

[Faint text at the bottom of the page, including what appears to be a signature or date on the left.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VR-15. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 23b Film G397 1/25/68 kk | | | | | | | | | | | |
|--|--|----------------------------------|--|---|---|-------------------------------------|---|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY AA | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | c. LENGTH OF STAY IN 1b
7 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE 21225 | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | | d. STREET ADDRESS
401 GIBBONS AVENUE | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle C. Last MELVIN | | | | | 4. DATE OF DEATH
Month DECEMBER Day 22 Year 19 67 | | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
NEGRO | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH
11/25/88 | | 9. AGE (In years last birthday) yrs. 79 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
TRACK WALKER | | | 10b. KIND OF BUSINESS OR INDUSTRY
RAIL ROAD | | 11. BIRTHPLACE (State or foreign country)
ENGLAND | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
HENRY MELVIN | | | | | 14. MOTHER'S MAIDEN NAME
RACHEL MC COY | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | | 16. SOCIAL SECURITY NO.
220 12 88 69 | | 17. INFORMANT
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
916.0 IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) SMOKE INHALATION
DUE TO
(c) SECOND DEGREE BURNS OF CHEST | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 DAYS
1 WEEK
9 DAYS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Put burning material in pocket & coughed on fire. | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 12-13 19 67 p.m. | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)
Home | | 20f. (City or town) (County) (State)
Balto Md | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
M B Davis | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| EXAMINER'S NAME (Type)
MELVIN B. DAVIS, M. D. | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | | 23b. DATE THEREOF
12-26-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | |
| 24. FUNERAL DIRECTOR
ISIAH BROWN FUNERAL HOME | | | | | 25a. REC'D BY REGISTRAR
JAN 12 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
J. J. Judge | |
| | | | | | DATE
12/22/67 | | | | | | |

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Put down water - front of house
✓ 18-12-61

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- 1800 MORNING 1st - 1st

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|---|--|---|--|--|--|---|--|---|--|--|--|---|--|--|--|--|--|
| 16611 | | | | | | | | | | | | 16604 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | c. LENGTH OF STAY IN 1b | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1135 Granville Rd., Baltimore 7, Md. | | | | | | | | | | | | d. STREET ADDRESS
1135 Granville Rd. | | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print) Edward Edwin Miller | | | | | | | | | | | | 4. DATE OF DEATH Dec. 13, 1967 | | | | | | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 12, 1903 | | | | 9. AGE (In years last birthday) yrs. 64 | | | | IF UNDER 1 YEAR
Months Days Hours Min. | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Hollinger Gulf Oil | | | | | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
Michael Chmielewski | | | | | | | | | | | | 14. MOTHER'S MAIDEN NAME
Johanna Kroeger | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | | | 16. SOCIAL SECURITY NO.
213-14-2872 | | | | | | 17. INFORMANT
Mr. Edward H. Miller, 3101 Northwind Rd. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Stomach & general
DUE TO Metastases
(b) Thrombosis
DUE TO Thrombosis
(c) Thrombosis | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Operation 9 yrs ago | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 9, 1952 to Dec 13, 1967 , that (I) (we) last saw the deceased alive on Dec 12, 1967 , and that death occurred at 7 AM , from causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
Nathan E. Needle M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22b. DATE SIGNED
12/15/67 | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
NATHAN E. NEEDLE | | | | | | 22d. ADDRESS
6506 Park Hyatt Dr | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
Dec. 16, 1967 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Lakeview Memorial Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Randallstown, Baltio., Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Frank H. Sewell, Pikesville, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 18 1967 | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | |

00504

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|-------------------------------|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson
c. LENGTH OF STAY IN 1b 12 days | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 304 city | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital | | | | | | d. STREET ADDRESS 5111 Green Oak Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) George William Miller | | | | | | 4. DATE OF DEATH Dec. 30 1967 | | | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-25-1877 | | 9. AGE (In years last birthday) 90 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager - President Life Ins Co | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY W. Va. | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) W. Va. | | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME John Miller | | | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Miller | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | | | 16. SOCIAL SECURITY NO. 215-10-5443 | | | | | |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4200 Arteriosclerotic Heart disease
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 mos. | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0021 Far Advanced pulmonary Tuberculosis | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 18, 1967 to Dec. 30, 1967 that (I) (we) last saw the deceased alive on Dec. 30 1967 , and that death occurred at 8:45 AM , from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE W. Newcomer | | | | | | 22b. DATE SIGNED | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent | | | | | | 22d. ADDRESS Mount Wilson, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 23b. DATE THEREOF 1-2-68 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | | | 23d. LOCATION (City or Town) (County) (State) Balto, Md. | |
| 24. FUNERAL DIRECTOR Elsworth Armacost | | | | | | 25a. REC'D BY REGISTRAR JAN 2 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

1961

Baltimore

Mount Wilson

Mount Wilson State Hospital

Mount Wilson State Hospital

Mr. Newcomer, R.D., Superintendent, Mount Wilson, Maryland

16613

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16606

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Pennsylvania</u>
b. COUNTY <u>✓</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Essex</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Upper Black Eddy</u> 75-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>BALTO YACHT CLUB</u> | | d. STREET ADDRESS
<u>Chestnut Ridge Road</u> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Gerald F. Miller</u> | | 4. DATE OF DEATH
Month Day Year
<u>12-9-1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan. 11, 1947</u> |
| 9. AGE (In years last birthday) yrs.
<u>20</u> | | IF UNDER 1 YEAR
Months Days Hours Min.
<u>9-19-67</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Seaman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>US Coastguard</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Lloyd James Miller</u> | | 14. MOTHER'S MAIDEN NAME
<u>Setpanen Siakka</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>210-38-9851</u> | |
| 17. INFORMANT
<u>Records-U.S. Coastguard</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Drowning</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>11-14</u> 19 <u>67</u>
p.m. | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ches. Bay</u>
20f. (City or town) (County) (State)
<u>Off Packer Island Bait Md.</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>M.B. Davis</u> | | 22. DATE SIGNED
<u>12/19/67</u> | |
| EXAMINER'S NAME (Type)
<u>M.B. DAVIS M.D.</u> | | 23a. REC'D BY REGISTRAR
<u>DEC 11 1967</u> | |
| 23b. DATE THEREOF
<u>Dec. 12, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Upper Tinicum</u> | |
| 23d. LOCATION (City or Town) (County) (State)
<u>Upper Black Eddy, Penna.</u> | | 23e. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| 24. FUNERAL DIRECTOR
<u>Howard County Funeral Home of Harry H. Witzke, Ellicott City, Md.</u> | | | |

1955

1955



1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 24 Film 6396 1/1/68 rr | | | | | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|---|--|--|--|
| 16614 | | | | | | 16607 | | | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | | | |
| a. COUNTY
BALTIMORE | | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TOWSON | | | c. LENGTH OF STAY IN 1b | | | d. STREET ADDRESS
3039 THIRD AVE. #21234 | | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | f. COUNTY
BALTIMORE | | | g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson Parkville | | | h. 03.1 | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | | 4. DATE OF DEATH | | | | | | | |
| First
ANNABELLE | | | Middle
THERESA | | | Last
MILLILI | | | Month
DECEMBER | | | | |
| 5. SEX
FEMALE | | | 6. COLOR OR RACE
WHITE | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | 8. DATE OF BIRTH
OCTOBER 3, 1928 | | | | |
| 9. AGE (In years last birthday)
39 yrs. | | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | | 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania | | | 12. CITIZEN OF WHAT COUNTRY
USA | | | | |
| 13. FATHER'S NAME
Charles Wahler | | | | | | 14. MOTHER'S MAIDEN NAME
Adlyn Pillard | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No None | | | | | | 16. SOCIAL SECURITY NO. | | | | | | | |
| 17. INFORMANT
Family records | | | | | | Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Massive intracerebral hemorrhage | | | | | | | | | | | | | |
| DUE TO (b) Rupture of Berry aneurysm of left | | | | | | | | | | | | | |
| DUE TO (c) middle cerebral artery | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from DECEMBER 24, 1967 , to December 25, 19 67 that (I) (we) last saw the deceased alive on DECEMBER 25 19 67 , and that death occurred at 1:10AM , from causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
Sam G. Misanik | | | | | | 22b. DATE SIGNED
12-25-67 | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Lawrence Misanik, M.D. | | | | | | 22d. ADDRESS
7620 York Road, Towson, Md. 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
Dec. 29, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Sepcular Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Cheltenham Twp., Montgomery Co. | | | |
| 24. FUNERAL DIRECTOR
John Burn's Sons | | | | | | 25a. REC'D BY REGISTRAR
Towson, Maryland | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | DATE
DEC 28 1967 | | | | | | | |

10001

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Native American
History of the
State of New York

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16615

16608

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Roundabouts Town Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Woodlawn</u> <u>21207</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Baltimore County General Hospital</u> | | d. STREET ADDRESS
<u>3605 Marmon Ave</u> | |
| 3. NAME OF DECEASED (Type or print)
<u>Ross F. Mitten</u> | | 4. DATE OF DEATH
Month <u>12</u> Day <u>13</u> Year <u>1967</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/3/1891</u> 9. AGE (In years lost birthday) <u>76</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Plumber</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>Westminster, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Frank J. Mitten</u> | | 14. MOTHER'S MAIDEN NAME
<u>Buckingham</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>218-18-2791</u> | |
| 17. INFORMANT
<u>Ivy Rebecca Mitten</u> | | Address
<u>3605 Marmon Avenue</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>443X</u>
IMMEDIATE CAUSE (a) <u>Cardio-vascular Disease</u>
DUE TO
(b) _____
DUE TO
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Hypertension</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>J. N. Frederick MD</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>J. N. Frederick MD</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>12-16-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Lorraine Park Cemetery Baltimore, Maryland</u> | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR <u>4600 Liberty Heights Avenue</u>
<u>Ellsworth Armacost Funeral Chapel</u> | | 25a. REC'D BY REGISTRAR
<u>DEC 15 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | 25c. REGISTRAR'S SIGNATURE | |

1881

1888

WIND AT 1000 HOURS 10-10-10

1881

WIND AT 1000 HOURS 10-10-10

WIND AT 1000 HOURS 10-10-10

WIND AT 1000 HOURS 10-10-10

WIND AT 1000 HOURS 10-10-10

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WIND AT 1000 HOURS 10-10-10

WIND AT 1000 HOURS 10-10-10

WIND AT 1000 HOURS 10-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|---|--------------------------------------|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 16616 Item#3 Film#G399 3/27/68 ph | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 16609 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Port Howard
c. LENGTH OF STAY IN 1b
27 days | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | | | | d. STREET ADDRESS
2811 Bayonne Avenue | | | | |
| 3. NAME OF DECEASED (Type or print)
HARRY SCOTT MONKS JR. | | | | | 4. DATE OF DEATH
Month DECEMBER Day 31 Year 1967 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5/12/99 | | 9. AGE (In years last birthday) yrs. 68 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Post Office | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Harry S. Monks | | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Lingan | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WWII | | 16. SOCIAL SECURITY NO.
408-44-57-70 | | 17. INFORMANT
Address
Clin. Rec. VAH, Fort Howard, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF THE PANCREAS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
CHRONIC PASSIVE CONGESTION OF LIVER. PULMONARY EMPHYSEMA. | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
MONTHS |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19
p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/4/ , 19 67 , to 12/31/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/31/ 19 67 , and that death occurred at 9:15AM from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Jose A. Raquel Jr. M.D. | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
JOSE A. RAQUEL, JR. M.D. | | | | | 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
1/5/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Miami Memorial Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Miami, Florida | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck Inc. | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 4 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | |

12

Veterans Administration Hospital

Clark
U.S. Post Office
Baltimore, Maryland
U.S.A.

Yes 100-1-52-70 GILB, JAC. VAN, Fort Howard, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16617

16610

| | | | |
|---|----------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Shady-Nook Nursing Home</u> | | d. STREET ADDRESS
<u>51 Overbrook Rd.</u> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Augusta</u> Middle <u>Morfoot</u> Last | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>7</u> Year <u>1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3/5/87</u> |
| 9. AGE (In years lost birthday)
<u>80</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Jentner</u> | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Mr. Robert M. Morfoot, Jr.</u>
<u>4110 Beechwood Rd. - 21222</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u>
DUE TO <u>Arteriosclerotic Myocardial Degeneration</u>
DUE TO <u>Generalized arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>o.m.</u> Month, Day, Year <u>19</u>
p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>7 Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7 Dec</u> 19 <u>67</u> , and that death occurred at <u>11:30 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>William J. Bryson</u> | | 22b. DATE SIGNED
<u>8 Dec 67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>William J. Bryson</u> | | 22d. ADDRESS
<u>4605 Edmondson Av.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>12/9/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Western Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Witzke F. D. - 4101 Edmondson Av.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 11 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

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Morris, didn't have any relations that...

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16618

16611

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
179 DAYS | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ODENTON | | d. STREET ADDRESS
1430 ANNAPOLIS ROAD | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
WILLIAM R. MORRISON | | 4. DATE OF DEATH
Month Day Year
DECEMBER 10 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MARCH 22, 1920 |
| 9. AGE (In years lost birthday) yrs.
47 | | 10. IF UNDER 1 YEAR Months Days Hours Min.
47 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LANDSCAPER HELPER | | 10b. KIND OF BUSINESS OR INDUSTRY
LANDSCAPER | |
| 11. BIRTHPLACE (County & State, or foreign country)
DRURY, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HARRY MORRISON | | 14. MOTHER'S MAIDEN NAME
MINA ALLISON | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service)
YES PL 28 | | 16. SOCIAL SECURITY NO.
216 18 54 98 | |
| 17. INFORMANT
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
491X
DUE TO
(b) GLIOMA OF BRAIN
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
RECENT | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/14/67 , 19__, to 12/10/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/10/67 , 19__, and that death occurred at 11:30 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Peter V. Juvan</i> | | 22b. DATE SIGNED
12/11/67 | |
| 22c. PHYSICIAN'S NAME (Type)
PETER V. JUVAN, M. D. | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12/14/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN MEMORIAL | | 23d. LOCATION (City or Town) (County) (State)
GLEN BURNIE, MD. | |
| 24. FUNERAL DIRECTOR
<i>Robert P. Juvan</i> | | 25a. REC'D BY REGISTRAR
GLEN BURNIE, MD. | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | DATE
DEC 12 1967 | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|--|----------------------------------|--|-------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 16619 | | | |
| 16612 | | | |
| CERTIFICATE OF DEATH | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY - | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
27yrlmthldy | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL+ | | d. STREET ADDRESS
103 East 25th Street | |
| 3. NAME OF DECEASED
(Type or print)
Anna | | 4. DATE OF DEATH
Month December Day 11 Year 67 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-21-86 |
| 9. AGE (In years last birthday)
81 yrs. | | 10. IF UNDER 1 YEAR
Months 11 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
saleslady | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Sigmund Dengler | | 14. MOTHER'S MAIDEN NAME
Catherine Hergle | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage or Infarction
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c) Arteriosclerosis, Generalized, Senile | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
none except Arteriosclerotic cardiovascular Ht. Dis. | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN DEATH AND EXAMINATION
12 hours | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 10 , 19 67 to Dec. 11 , 19 67 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on Dec. 11 , 19 67 , and that death occurred at 6:45 M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Anthony J. Young, M.D. | | 22b. DATE SIGNED
12-11-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/14/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Ulrich Funeral Home 4210 Belair Road. | | 25a. REC'D BY REGISTRAR
DATE DEC 15 1967 | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Jones | | | |

16813

OFFICE OF THE

16813

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "OFFICE OF THE" and "16813" are visible.]

CERTIFICATE OF DEATH

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
1032 Deanwood Road, 21234 | |
| 3. NAME OF DECEASED (Type or print)
First Baby Middle Girl Last MUIR | | 4. DATE OF DEATH
Month December Day 16 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-16-67 |
| 9. AGE (In years lost birthday) yrs. 30 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
William Muir | | 14. MOTHER'S MAIDEN NAME
Marguerite R. Mitchell | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Immaturity
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12-16 , 19 67 , to 12-16 , 19 67 , that (I) (we) last saw the deceased alive on 12-16 , 19 67 , and that death occurred at 12:25 from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Jose A. Aguto</i> | | 22b. DATE SIGNED
12-16-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Jose A. Aguto | | 22d. ADDRESS
7620 York Road, Baltimore, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
5-17-68 | 23c. NAME OF CEMETERY OR CREMATORY
Univ of Md. Med School | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR
DATE MAY 20 1968 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 16613 | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville, Maryland | | c. LENGTH OF STAY IN 1b
2yrs; 1mo; 20days; c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore City | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
College Manor, Lutherville, Maryland | | d. STREET ADDRESS
14 W. Cold Spring Lane, Balto, 10 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
IDA HAYES MULLINIX | | 4. DATE OF DEATH
Month Day Year
DECEMBER 5th., 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-15-1876 |
| 9. AGE (In years last birthday) yrs.
91 | | IF UNDER 1 YEAR
Months Days Hours Min.
30 4 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Montgomery County, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Julius Augustus Crockett | | 14. MOTHER'S MAIDEN NAME
Mary Margaret Watkins | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-01-9835 | |
| 17. INFORMANT
Mrs. Helen Parrish
321 Murdock Rd. - 21212 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac decompensation
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Arteriosclerotic cardiovascular disease 5 yrs.
(c) Arteriosclerosis, general 15 yrs. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Senile dementia | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 26, 1967 , to Dec. 5, 1967 , that (I) (we) last saw the deceased alive on Nov. 26, 1967 , and that death occurred at 6:45 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John Tilden Howard | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
John Tilden Howard | | 22d. ADDRESS
12 E. Eager St., Balt | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12/8/67 | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Witzke's Funeral Home | | 25a. REC'D BY REGISTRAR
DATE DEC 7 1967 | |
| ADDRESS
4101 Edmonson Ave | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| 16621 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 16614 | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>Balto</u> | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cockeysville</u> | | | | c. LENGTH OF STAY IN 1b
<u>14 yrs 2 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Balto.</u> | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>md. Masonic Home</u> | | | | | | d. STREET ADDRESS
<u>1729 Wilkins Ave</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Mary Manetta murr</u> | | | | | | 4. DATE OF DEATH
<u>12</u> Month <u>10</u> Day <u>19</u> Year <u>67</u> | | | | | | | |
| 5. SEX
<u>F</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>10-13-1890</u> | | 9. AGE (In years lost birthday)
<u>77</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Seamstress</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Balto. Md.</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>Robert Thomas Harris</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Elizabeth Gittings</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Masonic Home Records.</u> Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4 Cerebrovascular accident Lt</u>
DUE TO <u>2nd Hemiplegia</u>
(b) <u>3 Cerebral Arteriosclerosis</u>
DUE TO <u>3 Von Recklinhausen disease</u>
(c) <u>3 Von Recklinhausen disease</u> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>65</u> , to <u>Dec 8</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Dec 8</u> , 19 <u>67</u> , and that death occurred at <u>1:30 AM</u> , from causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
<u>JAMES H HAMED MD.</u> | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>12/10/67</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JAMES H HAMED MD.</u> | | | | | | 22d. ADDRESS
<u>MASONIC HOME Cockeysville</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>DEC. 13, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Woodlawn Cemetery</u> | | | | 23d. LOCATION (City or Town) (County) (State)
<u>Woodlawn Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR
<u>Wm Cook-Brooks Towson</u> | | | | | | ADDRESS
<u>1050 York Road Towson, Md</u> | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 13 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

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CONFIDENTIAL

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND-21201

16622

CERTIFICATE OF DEATH

16615

| | | | | | |
|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1301 Black Friars Rd. | | | d. STREET ADDRESS
1301 Black Friars Rd. | | |
| 3. NAME OF DECEASED
(Type or print) Neva E. Murray | | | 4. DATE OF DEATH
Month Dec. Day 30 Year 67 | | |
| 5. SEX
F | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
7/10/1891 | | 9. AGE (In years lost birthday) yrs. 76 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Balto., Md. | |
| 13. FATHER'S NAME
Late Daniel W. Myer | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mr. John Murray Address 1301 Black Friars Rd. Catonsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
1991
DUE TO
(b) Sarcoma, left arm
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 hrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
P.S.C.V. disease. Hypertension | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 'a.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from July , 19 67 , to Dec. 30 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 28 , 19 67 , and that death occurred at 3:25 PM , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
D.C. MacLaughlin | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
1/2/68 | |
| 22c. PHYSICIAN'S NAME (Type)
D. C. MacLaughlin | | 22d. ADDRESS
303 N. Rolling Road | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
1/3/68 | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | 23d. LOCATION (City or Town) (County) (State)
Balto., Md. | | |
| 24. FUNERAL DIRECTOR
Witzke F. D. - 4101 Edmondson Ave. Balto., Md. 21229 | | | 25a. REC'D BY REGISTRAR
DATE JAN 3 1968 | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

16623

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16616

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph's Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
WALTER LOUIS MYERS, Jr. | | 4. DATE OF DEATH
Month Day Year
December 18, 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 27, 1934 |
| 9. AGE (In years lost birthday)
33 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Contractor, | | 10b. KIND OF BUSINESS OR INDUSTRY
Home Improvement | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Walter L. Myers, Sr., | | 14. MOTHER'S MAIDEN NAME
Mary Scharnagle | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes 1951-1955 | | 16. SOCIAL SECURITY NO.
213-30-4465 | |
| 17. INFORMANT
Walter L. Myers, Sr. | | Address
4247 Shamrock Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4221
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Werner U. Spitz
EXAMINER'S NAME (Type)
Werner U. Spitz, M.D. | | 22. DATE SIGNED
12/19/67 | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/21/67 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery |
| 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | 23e. REGISTRAR'S SIGNATURE
Charles J. J... | |
| 24. FUNERAL DIRECTOR
Ullrich Funeral Home 4210 Belair Road. | | 25. REC'D BY REGISTRAR
DATE DEC 22 1967 | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore,
CATONSVILLE
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Catonsville | | c. LENGTH OF STAY IN 1b
21 months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SHAGRI - LA NURSING HOME | | d. STREET ADDRESS
614 S. Washington St. #21231 | |
| 3. NAME OF DECEASED (Type or print)
First VICTORIA Middle NADOLNY Last | | 4. DATE OF DEATH
Month 12 - Day 21 - Year 1967 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1889
October 29, 1889 |
| 9. AGE (In years last birthday)
77 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife - Canner | | 10b. KIND OF BUSINESS OR INDUSTRY
Packing House | |
| 11. BIRTHPLACE (County & State, or foreign country)
Poland | | 12. CITIZEN OF WHAT COUNTRY?
Poland | |
| 13. FATHER'S NAME
Frank Wiatrowski | | 14. MOTHER'S MAIDEN NAME
Mary Cyganek | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-01-7019 | |
| 17. INFORMANT
Stanislaus Nadolny - 614 S. Washington St. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO
(b) Cachexia
DUE TO
(c) Diabetes - Multiple Decubiti - Senility | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-2- , 19 66 , to 12-21- , 19 67 , that (I) (we) last saw the deceased alive on 12-21- , 19 67 , and that death occurred at 1A M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Cesar Valle Caverio | | 22b. DATE SIGNED
12-21-67 | |
| 22c. PHYSICIAN'S NAME (Type)
CESAR VALLE CAVERO | | 22d. ADDRESS
8624 Liberty Rd | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/23/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
George A. Weber - 705 S. Ann St. #21231 | | 25a. REC'D BY REGISTRAR
DATE DEC 26 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16625

CERTIFICATE OF DEATH

16618

| | | | | | |
|--|------------------------------|--|--------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Towson
c. LENGTH OF STAY IN 1b
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
St. Joseph's Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Towson
d. STREET ADDRESS
954 Dulaney Valley Road
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First
Beulah
Middle
C.
Last
Naylor | | 4. DATE OF DEATH
Month
12
Day
26
Year
1967 | | | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-20-1892 | 9. AGE (In years last birthday)
75 yrs. | 10. IF UNDER 1 YEAR
Months
7
Days
19
Hours
67
Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Levi Lee Chambers | | 14. MOTHER'S MAIDEN NAME
Florence Hare | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
218-03-1856 | | 17. INFORMANT
Mrs. Marie C. Schaefer
Address
802 Mockingbird Lane | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
410X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic C.V.D.
DUE TO (c) Rheumatic mitral disease | | | | | INTERVAL BETWEEN ONSET AND DEATH
Few hours
5 years
60 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 17, 1967 , to Dec. 26, 1967 , that (I) (we) last saw the deceased alive on Nov. 17, 1967 , and that death occurred at 4:00 M., from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Louis E. Wice | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
12/28/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Louis E. Wice | | 22d. ADDRESS
920 St. Paul Street Balto., Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12-29-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | |
| 23d. LOCATION (City, town or county)
Baltimore, Co., Md. | | 23e. LOCATION (City, town or county) (State) | | | |
| 24. FUNERAL DIRECTOR
H. W. Jenkins & Sons Co.
4905 York Rd. Balto., Md. | | ADDRESS
21212 | | 25a. REC'D BY REGISTRAR
DATE JAN 2 1968 | |
| 25b. REGISTRAR'S SIGNATURE
W. C. ... | | 25c. REGISTRAR'S SIGNATURE
W. C. ... | | | |



1952



Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16627

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| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | c. LENGTH OF STAY IN 1b
Dundalk | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Dunleer Apts. | | d. STREET ADDRESS
Dunleer Apts, | |
| 3. NAME OF DECEASED (Type or print)
First Milton Middle L. Last Novotny | | 4. DATE OF DEATH
Month Dec. Day 31, Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 24, 1892 |
| 9. AGE (In years last birthday)
75 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tin mill | | 10b. KIND OF BUSINESS OR INDUSTRY
Steel | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Novotny | | 14. MOTHER'S MAIDEN NAME
? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW 1 | | 16. SOCIAL SECURITY NO.
WW 1 | |
| 17. INFORMANT
Mrs. Anna Goetz 7610 Bagley Ave. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction + A-S-C-V disease
DUE TO (b) Heart disease
DUE TO (c) Heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
M.B. Davis | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
M.B. Davis, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town, or county)
6800 Mornington Rd. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
January 4, 68 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Ullrich Funeral Home 4210 Belair Road. | | 25a. REC'D BY REGISTRAR
JAN 5 1968 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] | |

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16621

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Essex (21) | | | | c. LENGTH OF STAY IN 1b
Essex (21) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1511 Nicolay Way | | | | d. STREET ADDRESS
1511 Nicolay Way | | | |
| 3. NAME OF DECEASED
(Type or print) HUBERT OWEN O'DAIR | | | | 4. DATE OF DEATH
Month December Day 3 Year 1967 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
April 1, 1900 | |
| 9. AGE (In years lost birthday) 67 yrs. | | IF UNDER 1 YEAR
Months 67 Days 67 Hours 67 Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | 11. BIRTHPLACE (State or foreign country)
Illinois | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
Steel Mill | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Abe O'Dair | | | | 14. MOTHER'S MAIDEN NAME
Dorothy Adair | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO.
213 09 3218 | | 17. INFORMANT
Same | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
4201 IMMEDIATE CAUSE (a) Acute Coronary Occlusion
DUE TO HCD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HCD
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Theo. C. Patterson | | | | 22. DATE SIGNED 12/2/67 | | | |
| EXAMINER'S NAME (Type) Theodore Patterson, M.D. | | | | 105 Main St. Dundalk, Md. 21222 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/6/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Balto. National Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Brudzinski Funeral Home 1407 Eastern Ave. | | | | 25a. RECEIVED BY REGISTRAR
DEC 6 1967 | | 25b. REGISTRAR'S SIGNATURE
John J. Jones | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16629

CERTIFICATE OF DEATH

16622

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
SHANGRI-LA MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN lb
3 years | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Westminster | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SHANGRI-LA NURSING HOME | |
| d. STREET ADDRESS
65 Hook Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Katie L. OGLE | | 4. DATE OF DEATH
12-4-1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 26, 1886 |
| 9. AGE (In years last birthday)
81 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Carroll Co., Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Rezin Farver | | 14. MOTHER'S MAIDEN NAME
Katie Haines | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
218-50-6034 | |
| 17. INFORMANT
Mrs. Florine Cook | | Address
Same As #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
DUE TO (b) Thrombosis of L. Iliac artery
DUE TO (c) and gangrene Entire L. Leg | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
C.V.A. & L. side hemiparesis | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1-5- , 1966, to 11-4- , 1967, that (I) (we) last saw the deceased alive on 12-4- , 1967, and that death occurred at 3:45 PM , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Cesar Valle Caverio | | 22b. DATE SIGNED
12-4-67 | |
| 22c. PHYSICIAN'S NAME (Type)
CESAR VALLE CAVERO | | 22d. ADDRESS
8629 Liberty Rd Randallstown | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12/7/1967 | 23c. NAME OF CEMETERY OR CREMATORY
Taylorsville Cemetery | 23d. LOCATION (City or Town) (County) (State)
Carroll Co., Md. |
| 24. FUNERAL DIRECTOR
C. M. Waltz | | 25a. REC'D BY REGISTRAR
DEC 7 1967 | |
| ADDRESS
Box 241 Sykesville, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16630

16623

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE West Virginia b. COUNTY Parsons | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | c. LENGTH OF STAY IN lb
253 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
66 Transverse Ave. 21220 | | d. STREET ADDRESS
234 Billings Ave. | |
| 3. NAME OF DECEASED (Type or print)
CRESSIE First MAE Middle OLDAKER Last | | 4. DATE OF DEATH
Month 12 Day 22 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/13/98 |
| 9. AGE (In years lost birthday) yrs.
69 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | |
| 11. BIRTHPLACE (State or foreign country)
W. Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Baxter Shaffer | | 14. MOTHER'S MAIDEN NAME
Lusendy Katherine - - | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Dortha Mae Sanders, 66 Transverse Ave. | | Address 21220 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
DUE TO HEVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes mellitus | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Thos C. Patterson M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type or print)
Thos C. Patterson | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED
12/22/67 | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| Address (Street, city, town, or county) | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | |
| 23b. DATE THEREOF
12/24/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Parsons City Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Parsons W. Va. | | 24. FUNERAL DIRECTOR
Howard H. Hubbard Funeral Home, 4107 Wilkens Ave. | |
| 25a. REC'D BY REGISTRAR
DEC 27 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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THE NEW YORK PUBLIC LIBRARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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16624
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Towson | | | | c. LENGTH OF STAY IN 1b
KINGSVILLE 21087 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
GREATER BALTIMORE Medical Center | | | | d. STREET ADDRESS
MOHR RD. | | | |
| 3. NAME OF DECEASED (Type or print)
First ANDREW Middle JOHN Last PANZER, Sr. | | | | 4. DATE OF DEATH
Month December Day 30 Year 1967 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
CAUC. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1-29-19 | |
| 9. AGE (In years last birthday)
48 yrs. | | 10. IF UNDER 1 YEAR
Months 4 Days 8 Hours 0 Min. | | 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MD. | | 12. CITIZEN OF WHAT COUNTRY?
UNITED STATES | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CARPENTER | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. FATHER'S NAME
ANDREW PANZER | | | | 14. MOTHER'S MAIDEN NAME
MARGARET STREHLEN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
YES | | 16. SOCIAL SECURITY NO.
1942-1946 | | 17. INFORMANT
Mrs. Agnes M. Panzer | | Address
(Same) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 163X Myocardial infarction, large + small
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-26 , 19 67 , to 12-30 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 30 , 19 67 , and that death occurred at 2:50 PM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Anastacia Fabie | | | | 22b. DATE SIGNED
12-30-67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
ANASTACIA FABIE | | | | 22d. ADDRESS
GREATER BALT. Med. CENTER | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
1/13/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | 25a. REC'D BY REGISTRAR
JAN 2 1968 | | | |
| 25b. REGISTRAR'S SIGNATURE
James J. Judge | | | | | | | |

1881

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2100

210-1-030 (name)
Preston, or, long & short

Charles John
Kathleen Fisher
George Bell Man Center
✓ 12-30-67

Woodward Center
173/00
12-30-67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

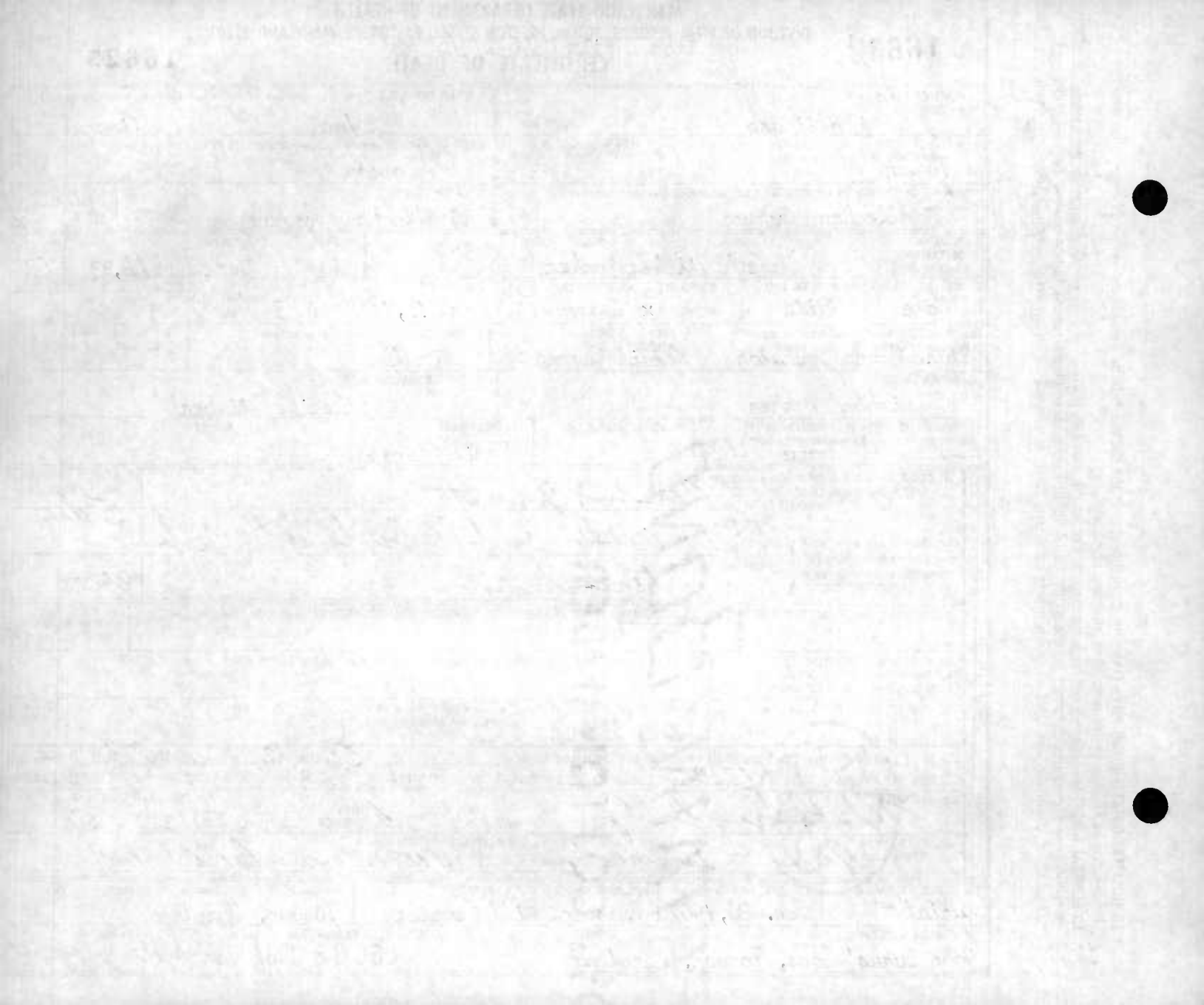
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | c. LENGTH OF STAY IN lb <u>03-1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>35 Alleghany Avenue</u> | | d. STREET ADDRESS <u>35 Alleghany Avenue</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Joseph Stieber Parker</u> | | 4. DATE OF DEATH <u>December 23, 1967</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 17, 1884</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | 10. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Richard Parker</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine Stieber</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Family Records</u> | | 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u>
DUE TO <u>Less Middle Cerebral Artery Occlusion</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u>
(c) <u>Arteriosclerosis</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-22-67</u> to <u>12-22-67</u> , that (I) (we) last saw the deceased alive on <u>12-22-67</u> , and that death occurred at <u>7:45 A.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Kyle G. Swisher Jr.</u> | | 22b. DATE SIGNED <u>12-26-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Kyle G. Swisher Jr.</u> | | 22d. ADDRESS <u>V.N.D. Hsp - Bald 1, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Dec. 26, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Towson, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>DEC 28 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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|--|--|---|--|--|---|
| 16633 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 16626 | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
4yrs 4mo | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bel Air Md. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Spring Grove State Hospital | | | | d. STREET ADDRESS
141 Fairmont Drive | |
| 3. NAME OF DECEASED
(Type or print) Catherine Estelle Parr | | | | 4. DATE OF DEATH
Month 12 Day 15 Year 19 67 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12 2 1895 | 9. AGE (In years lost birthday)
72 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
New York | |
| 13. FATHER'S NAME
Unknown | | | 14. MOTHER'S MAIDEN NAME
Unknown | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Hospital records | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4500 CARDIAC FAILURE
DUE TO days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Generalized arteriosclerosis
DUE TO year
(c) | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 19 to Dec 15, 19 67 , that (I) (we) last saw the deceased alive on Dec 15 19 67 , and that death occurred at 7:10 P.M. from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
George A. Rodon | | | 22b. DATE SIGNED
12-16-67 | | |
| 22c. PHYSICIAN'S NAME (Type)
George A. Rodon M.D. | | | 22d. ADDRESS
Spring Grove St. Hosp. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
12/20/67 | 23c. NAME OF CEMETERY OR CREMATORY
EAST LAWN | 23d. LOCATION (City or Town) (County) (State)
ITHACA, N.Y. | | |
| 24. FUNERAL DIRECTOR
E.S. MALNABE 301 FREDERICK RD 21228 | | 25a. REC'D BY REGISTRAR
OAT DEC 18 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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RECORDS OF THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 16634 | | | |
| 1662'7 | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Garrison
c. LENGTH OF STAY IN 1b
1 week
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Foxleigh Nursing Home | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reisterstown
d. STREET ADDRESS
203 Greenview Ave.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Francis Xavier Patrick | | 4. DATE OF DEATH
Month December Day 24 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 4, 1900 |
| 9. AGE (In years last birthday)
67 yrs. | | IF UNDER 1 YEAR
Months 03 Days 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ass. Office Manager Stock Broker | | 10b. KIND OF BUSINESS OR INDUSTRY
Stock Broker | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph Patrick | | 14. MOTHER'S MAIDEN NAME
Isabelle Magness | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-09-4260 | |
| 17. INFORMANT
Catherine Patrick Reisterstown, Md | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
DUE TO (b) Arteriosclerosis - generalized
DUE TO (c) Emphysema
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
331X | |
| 19. INTERVAL BETWEEN ONSET AND DEATH
4 days | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July , 1967, to December 24 , 1967, that (I) (we) last saw the deceased alive on December 24 , 1967, and that death occurred at 11:40 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Clarence E. McWilliams | | 22b. DATE SIGNED
12-25-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Clarence E. McWilliams | | 22d. ADDRESS
11904 Reisterstown Rd Reisterstown, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Dec. 28, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Mem. Gardens | | 23d. LOCATION (City or Town) (County) (State)
Finksburg, Maryland | |
| 24. FUNERAL DIRECTOR
H. J. Eckhardt | | 25a. REC'D BY REGISTRAR
Owings Mills, Maryland | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE
DEC 28 1967 | |

1943

1943

UNITED STATES

Washington, D.C.

Division of Investigation

203 Broadway Ave.

December 29, 1943

May 11, 1900

U.S.A.

Isabella

203 Broadway Ave.

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CERTIFICATE OF DEATH

16628

16635

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | |
| c. LENGTH OF STAY IN lb
16 MO. | | d. STREET ADDRESS
7117 YORK ROAD | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ARMADOST NURSING HOME 812 REGESTER AVE - BALTO 21212 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) EMMA BEATRICE PATTEN | | 4. DATE OF DEATH
Month 12 Day 9 Year 1967 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
AUG-20, 1879 |
| 9. AGE (In years lost birthday)
83 yrs. | | 10. IF UNDER 1 YEAR
Months 9 Days 2 Hours 19 Min. 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 11. BIRTHPLACE (County & State, or foreign country)
RISING SUN, MD | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN KEILHOLTZ | | 14. MOTHER'S MAIDEN NAME
MARTHA EMMA KIRK | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
218-54-2853 | |
| 17. INFORMANT
ERKERSON K PATTEN | | Address 7117 YORK RD. BALTIMORE, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4500 IMMEDIATE CAUSE (a) Acute Cardiac Failure
DUE TO (b) Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)
DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH
1 yr |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from July 10, 1960 , to Dec 9, 1967 , that (I) (we) last saw the deceased alive on Dec 9, 1967 , and that death occurred at 5 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Lawrence C. Post | | 22b. DATE SIGNED
12/11/67 | |
| 22c. PHYSICIAN'S NAME (Type)
LAWRENCE C. POST | | 22d. ADDRESS
6705 York Rd - Baltimore 21220 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
12/12/67 | 23c. NAME OF CEMETERY OR CREMATORY
WESTNOTTINGHAM CEM. | 23d. LOCATION (City or Town) (County) (State)
COLORA CELIL MD |
| 24. FUNERAL DIRECTOR
RALPH M. REED | | 25a. REC'D BY REGISTRAR
DEC 11 1967 | |
| ADDRESS
RISING SUN, MD | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

16636

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16629

| | | | |
|---|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
c. LENGTH OF STAY IN 1b
Joppa
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital, Towson, Md. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore Joppa
d. STREET ADDRESS
706 Pulaski Highway
503 Stans Road
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
TRINA Baby MARIE Girl PAYTON | | 4. DATE OF DEATH
Month Day Year
December 8 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-5-67 |
| 9. AGE (In years lost birthday) yrs.
3 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | 10b. KIND OF BUSINESS OR INDUSTRY
none | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore Co., Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Johnnie Payton | | 14. MOTHER'S MAIDEN NAME
Reba Wooten | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Mrs. Reba Payton | | Address
706 Pulaski Highway, Joppa Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
DUE TO (b) 776X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-5-67 , 19 67 , to 12-8 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12-8 , 19 67 , and that death occurred at 8:15 p.m. from causes and on the date stated above. | | 22a. SIGNATURE
R. Orjuela-Gomez, M.D.
M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type)
R. Orjuela-Gomez, M.D. | | 22b. DATE SIGNED
12-9-67 | |
| 22d. ADDRESS
7620 York Road, Towson, Md. 21204 | | 22e. REC'D BY REGISTRAR
DEC 13 1967 | |
| 22f. REGISTRAR'S SIGNATURE
[Signature] | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | |
| 23b. DATE THEREOF
Dec. 11, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Harford Memorial Gardens | |
| 23d. LOCATION (City or Town) (County) (State)
Aberdeen Harford Md | | 24. FUNERAL DIRECTOR
Howard K. McComas & Son, Abingdon, Md. 21009 | |

1863

1863

OFFICE OF THE

RECORDS

RECORDS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

16637

CERTIFICATE OF DEATH

16620

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. 21213 b. COUNTY — | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Idlewilde | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Armcast Nursing Home | | d. STREET ADDRESS
2221 Lake Ave. | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First FRANCES Middle A. Last PETERKA | | 4. DATE OF DEATH
Month Dec. Day 25 Year 1967 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/8/1888 |
| 9. AGE (In years lost birthday) yrs.
79 | | IF UNDER 1 YEAR
Months Days Hours Min.
— | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
at home | 11. BIRTHPLACE (County & State, or foreign country)
Czechoslovakia |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Joseph Slechta | | 14. MOTHER'S MAIDEN NAME
unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Marie J. Peterka, dght. above | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Pancreas
157X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
10 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (his hospital) attended the deceased from Nov. 22, 1967 to Dec. 25, 1967 , that (I) (we) last saw the deceased alive on Dec. 24, 1967 , and that death occurred at 2:30 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. Loy Zimmerman | | 22b. DATE SIGNED
12/27/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Loy Zimmerman | | 22d. ADDRESS
3202 Harford Road | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12/28/67 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cem. | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Schumnek Funeral Home, Inc.
3331 Brehms Lane | | 25a. REC'D BY REGISTRAR
DATE DEC 28 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1883

1883

1883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|---|---|
| 16638 | | 16631 | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | c. LENGTH OF STAY IN lb
4yr9mth3dys | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly, Maryland | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | d. STREET ADDRESS
6106 Arbor Street | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
William Charles Petrie, Sr. | | 4. DATE OF DEATH
Month December Day 12 Year 1967 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 1, 1888 |
| 9. AGE (In years last birthday) yrs.
79 | | IF UNDER 1 YEAR
Months 12 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
plasterer | | 10b. KIND OF BUSINESS OR INDUSTRY
construction | 11. BIRTHPLACE (County & State, or foreign country)
Scotland |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. | | 13. FATHER'S NAME
William Petrie | |
| 14. MOTHER'S MAIDEN NAME
Mary McGovern | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Army WWI C 209 649 | |
| 16. SOCIAL SECURITY NO.
219-07-3474 | | 17. INFORMANT
Address
Records: SPRING GROVE STATE HOSPITAL | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, right lower lobe, organism 4 days
DUE TO unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malnutrition and dehydration
DUE TO with cerebral arteriosclerosis
(c) Anorexia and Chronic Brain Syndrome asso. | | INTERVAL BETWEEN ONSET AND DEATH
3 months
10 years. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Arteriosclerotic Cardiovascular Ht. Dis.; Decubitus Ulcer, | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that he (this hospital) attended the deceased from March 8, 1963 to Dec. 12, 1967 , that he (we) last saw the deceased alive on Dec. 12, 1967 , and that death occurred at 10:55 M, from causes and on the date stated above. | |
| 22a. SIGNATURE
Anthony J. Young, M.D. | | 22b. DATE SIGNED
12-13-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Catonsville, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12-16-67 | 23c. NAME OF CEMETERY OR CREMATORY
FORT LINCOLN | 23d. LOCATION (City or Town) (County) (State)
COLMAR MANOR, MARYLAND |
| 24. FUNERAL DIRECTOR
W.W. Chamber Co | | 25a. REC'D BY REGISTRAR
DATE DEC 18 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

1883

1883

RECORDS OF DEATH

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

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DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

CERTIFICATE OF DEATH

16632

16639

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
30.4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Shady Nook Nursing Home | | d. STREET ADDRESS
132 S. Collins Avenue | |
| 3. NAME OF DECEASED
(Type or print) Lucy V. Phebus
First Middle Last | | 4. DATE OF DEATH
Month December Day 9 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-12-1890 |
| 9. AGE (In years last birthday) yrs. 77 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Fuller Wright | | 14. MOTHER'S MAIDEN NAME
Mary Warfield | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Lois Frey, 132 S. Collins Ave. 21229 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ATHEROSCLEROTIC CV HEART DISEASE
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
2 WKS. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
DIABETES MELLITUS. BILATERAL LEG AMPUTATIONS. | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12/59 , 19 67 , to 12.9 , 19 67 , that (I) (we) saw the deceased alive on 12.9 19 67 , and that death occurred at 4:40 PM , from causes and on the date stated above | | | |
| 22a. SIGNATURE
Dr. John F. Schaefer | | 22b. DATE SIGNED
12/11/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. John F. Schaefer | | 22d. ADDRESS
401 Random Road, Balto. Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
12-13-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Jennings Chapel | 23d. LOCATION (City or Town) (County) (State)
Florence, Maryland |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Avenue 21229 | | 25a. REC'D BY REGISTRAR
DEC 12 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
20M 1/65

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1663.2

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|--|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE
MD | | b. COUNTY
— | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Towson | | c. LENGTH OF STAY IN 1b
17 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE 21224 | | 30-4 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Greater Baltimore Medical Center | | | | d. STREET ADDRESS
10 S. HIGHLAND AVE. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
Peter | | First
Paul | | Middle
Pietrowicz | | Last
12 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Cau | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11-22-96 | | | |
| 9. AGE (In years last birthday)
71 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LONGSHOREMAN | | 11. BIRTHPLACE (County & State, or foreign country)
PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
STANISLAW PIETROWICZ | | | | 14. MOTHER'S MAIDEN NAME
JOSEPHINE SCHOVERN | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
YES | | 16. SOCIAL SECURITY NO.
216-09-4683 | | 17. INFORMANT
ROSE PIETROWICZ | | Address
21224 10 S HIGHLAND | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carotid Artery hemorrhage
1410
DUE TO
(b) Carcinoma of base of tongue
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/24 , 19 67 , to 12/10 , 1967, that (I) (we) last saw the deceased alive on 12/10 , 19 67 , and that death occurred at 9:00 PM , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
John E. Adams | | | | M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
12/11/67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
John E. Adams, M.D. | | | | 22d. ADDRESS
6701 N. Charles Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12-14-67 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY ROSARY Cem. | | 23d. LOCATION (City, town or county) (State)
BALTO. Co. MD. | | | |
| 24. FUNERAL DIRECTOR
W. FIALKOWSKI | | | | 25a. REC'D BY REGISTRAR
DEC 13 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

1680

11-22-11

John E. Allen

1911

16641

CERTIFICATE OF DEATH

16634

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7814 Ruxway Road | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE Maryland
b. COUNTY —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 3009 Arunah Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Sylvia Middle Louise Last Pollard | | 4. DATE OF DEATH
Month 12 Day 5 Year 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 14, 1916 |
| 9. AGE (In years last birthday) 51 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | 11. BIRTHPLACE (County & State, or foreign country) Gloucester CO. VA. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Walker Pollard | |
| 14. MOTHER'S MAIDEN NAME Daisy Jones | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service) | |
| 16. SOCIAL SECURITY NO. 228-42-6047 | | 17. INFORMANT Mr Robert Pollard 3009 Arunah Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hypertensive cardio vascular disease.
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 29, 1967 to Nov 29, 1967 , that (I) (we) last saw the deceased alive on Nov 29, 1967 , and that death occurred at — M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE [Signature] M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 12/7/67 | |
| 22c. PHYSICIAN'S NAME (Type) TORROT JUDY, M.D. | | 22d. ADDRESS 549 N. Fulton Ave | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/9/67 | 23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cemetery | 23d. LOCATION (City, town or county) (State) Baltimore CO. MD. |
| 24. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Nutter ADDRESS 3035 W. NORTH AVE | | 25a. REC'D BY REGISTRAR DEC 12 1967 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
25M 1/67

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|--|----------------------------------|---|------------------------------------|--|---|---|--|
| 16642 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | | 16625 | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN lb
103 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | | 03.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
29 LINCOLN AVENUE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
LAWRENCE POLLOCK | | | | 4. DATE OF DEATH Month Day Year
DECEMBER 14 1967 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
5/18/21 | | 9. AGE (In years last birthday) yrs.
46 | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MILLWRIGHT | | 10b. KIND OF BUSINESS OR INDUSTRY
LUMBER | | 11. BIRTHPLACE (County & State, or foreign country)
TILER, ARKANSAS | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN POLLOCK | | | | 14. MOTHER'S MAIDEN NAME
MARY WILLIS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WWII | | 16. SOCIAL SECURITY NO.
218 07 63 63 | | 17. INFORMANT Address
CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
237x
IMMEDIATE CAUSE (a) TERMINAL BRAIN TUMOR
DUE TO
(b)
DUE TO
(c) | | | | INTERVAL BETWEEN ONSET AND DEATH
MONTHS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that XX (this hospital) attended the deceased from SEPT 2 , 19 67 , to DEC 14 , 19 67 , that X (we) last saw the deceased alive on DEC 14 , 19 67 , and that death occurred at 6:50P M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Sung Ill Shin</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
12/14/67 | |
| 22c. PHYSICIAN'S NAME (Type)
SUNG ILL SHIN, M.D. | | | | 22d. ADDRESS
VAH, FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12/19/67 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR
HERBERT NUTTER FUNERAL HOME BALTIMORE, MD. | | | | 25a. REC'D BY REGISTRAR
DEC 20 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

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CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTO | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
REISTERSTOWN | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
REISTERSTOWN | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MILFORD MANOR NCG HOME - | | | d. STREET ADDRESS
3504 COURTLEIGH RD 21207 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
First Dora Middle Postolsky Last KY | | | 4. DATE OF DEATH
Month 12 Day 1 Year 1967 | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/12/1892 | 9. AGE (In years last birthday)
75 yrs. | IF UNDER 1 YEAR
Months 1 Days 1 Hours 1 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MERCHANT | | 10b. KIND OF BUSINESS OR INDUSTRY
RETIRED | | 11. BIRTHPLACE (County & State, or foreign country)
RUSSIA | |
| 13. FATHER'S NAME
MORRIS HAMBURGER | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
177-28-1566 A | | 17. INFORMANT
Address
MRS. SYLVIA CAPLAN, 3504 COURTLEIGH DRIVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201 Myocardial Infarction
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO (b) Arterio sclerosis
DUE TO (c) cardiomy | | | | | INTERVAL BETWEEN ONSET AND DEATH
minutes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 11-13 , 19 67 , to 12-1 , 19 67 , that (II) (we) last saw the deceased alive on 11-26 , 19 67 , and that death occurred at 1:10 P M, from causes and on the date stated above | | | | | |
| 22a. SIGNATURE
David D. Miller | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
12-1-67 |
| 22c. PHYSICIAN'S NAME (Type)
David D. Miller | | | 22d. ADDRESS
Linson Rd. Owings Mill, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12-2-67 | | 23c. NAME OF CEMETERY OR CREMATORY
ROOSEVELT | |
| 24. FUNERAL BURIAL ADDRESS
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD. | | 23d. LOCATION (City or Town) (County) (State)
PHILADELPHIA, PENNSYLVANIA | | 25a. REC'D BY REGISTRAR
DEC 5 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ESTIMATE OF COST

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AMOUNT

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CERTIFICATE OF DEATH

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|---|----------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | | c. LENGTH OF STAY IN lb
23 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rosewood State Hospital | | | | d. STREET ADDRESS
1420 School Lane | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Doris Middle Marie Last PURVINES | | | | 4. DATE OF DEATH
Month 12 Day 27 Year 19 67 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-21-50 | | 9. AGE (In years last birthday)
17 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dependent | | 10b. KIND OF BUSINESS OR INDUSTRY
none | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore City, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Grant Leroy Purvines | | | | 14. MOTHER'S MAIDEN NAME
Viola Henrietta Warner | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no -- | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT Address
Rosewood Records, Owings Mills, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
500X
IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO
(b) Acute Bronchitis
DUE TO
(c) Chronic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2-3 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Cerebral Spastic Infantile Paralysis | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/11 , 19 66 , to 12/27 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/27 , 19 67 , and that death occurred at 12:05 P.m. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Harry G. Butler</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
12/27/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Harry G. Butler, M.D. | | | | 22d. ADDRESS
Rosewood St. Hosp., Owings Mills, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/31/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Pleasant Rest | | 23d. LOCATION (City or Town) (County) (State)
Towson, Balto. Co. Md. | |
| 24. FUNERAL DIRECTOR
Wm. J. Chaturman - 1701 McCallister St. | | | | 25a. REC'D BY REGISTRAR
DATE DEC 29 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15883

RECEIVED OF DEATH

15883

| | | | |
|------------------------|--|------------------------|--|
| Name of Deceased | | Date of Death | |
| Place of Birth | | Place of Death | |
| Occupation | | Cause of Death | |
| Manner of Death | | Burial Place | |
| Date of Burial | | Name of Burial Place | |
| Name of Informant | | Address of Informant | |
| Signature of Informant | | Signature of Registrar | |
| Date of Registration | | Place of Registration | |

16645

CERTIFICATE OF DEATH

16638

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Parkville | | | | c. LENGTH OF STAY IN 1b
03.1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
8100 Harford Road | | | | d. STREET ADDRESS
8501 School Road | | | |
| 3. NAME OF DECEASED (Type or print)
First Elwood Middle LeRoy Last QUICKEL | | | | 4. DATE OF DEATH
Month December Day 23 Year 1967 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH
July 31, 1904 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Supervisor | | 10b. KIND OF BUSINESS OR INDUSTRY
Post Office | | 11. BIRTHPLACE (County & State, or foreign country)
Penna. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Franklin Quickel | | | | 14. MOTHER'S MAIDEN NAME
Nettie Hoke | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-10-9511 | | 17. INFORMANT
Mrs Anna E Quickel | | Address
Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Hypertensive Arteriosclerosis Anterior
(c) Myocardial Infarction | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 months
17yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April , 19 56 , to Dec , 19 62 , that (I) (we) last saw the deceased alive on 12/23 19 62 , and that death occurred at 4:45 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Dr. S. Elliott Harris | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
12/23/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. S. Elliott Harris | | | | 22d. ADDRESS
8100 Harford Road | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/27/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | 25a. REC'D BY REGISTRAR
DEC 27 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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UNITED STATES DEPARTMENT OF JUSTICE

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VR A13
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | |
| HUBERT | | L. | | RADCLIFFE | | | | Dec. 14, 1967 | | 12:30 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| M | | W | | JAN. 24, 1896 | | 71 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Md. | | U.S. | | | | BALTIMORE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| CATONSVILLE | | SUMMIT HOME | | SHIP CAPTAIN | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | BALTO. | | CATONSVILLE | | | | 606 Edmondson Ave. | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | |
| George | | W. | | RADCLIFFE | | | | MARY ELIZABETH | | RAPPANICK | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| NO | | 391-16-7154 | | VIOLA S. RADCLIFFE | | 606 Edmondson Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> | | | | | | | | | | 2 1/2 yr. | |
| 4200 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| HOUR A.M. Month Day Year | | P.M. | | 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/14, 1964, to 12/14, 1967, that (I) (we) last saw the deceased alive on 12/14, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | |
| Robert A. Reiter, M.D. | | | | | | | | | | 12/16/67 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | |
| Robert A. Reiter M.D. | | | | | | | | | | 606 Edmondson Ave 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | Dec. 18, 1967 | | ST. Johns | | HOWARD Md | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| E. Mae Nabb | | 301 Frederick Rd BALTO. 21228 Md. | | DATE DEC 18 1967 | | James J. Jager | | | | | |

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DEPARTMENT OF HEALTH

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Hubert

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Mr

Mr

George W

Mr

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16647

16640

| | | | |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN 1b
64 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | d. STREET ADDRESS
2632 Liberty Parkway | |
| 3. NAME OF DECEASED
(Type or print) EDWARD HENRY REINERT | | 4. DATE OF DEATH
Month December Day 27 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
11/14/07 |
| 9. AGE (In years lost birthday) yrs. 60 | | 10. IF UNDER 1 YEAR
Months 6 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Time Keeper | | 10b. KIND OF BUSINESS OR INDUSTRY
Canning Industry | |
| 11. BIRTHPLACE (County & State, or foreign country)
Chapman, Penna. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Oliver Reinert | | 14. MOTHER'S MAIDEN NAME
Minnie Wertz | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
Yes WW-11 | | 16. SOCIAL SECURITY NO.
213 07 84 62 | |
| 17. INFORMANT
Clinical Rcds, VA Hospital, Fort Howard, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
163x
IMMEDIATE CAUSE (a) CARCINOMA OF LUNG
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
EMPHYSEMA, RIGHT CHEST. BRONCHO PNEUMONIA, LEFT LUNG | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 24 , 19 67 , to Dec. 27 19 67 , that (I) <input checked="" type="checkbox"/> we last saw the deceased alive on Dec. 27 , 19 67 , and that death occurred at 10:24 A.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John D. Talbert | | 22b. DATE SIGNED
12/27/67 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M.D. | | 22d. ADDRESS
VA Hospital, Fort Howard, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/30/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
ULLRICH FUNERAL HOME | | 25a. REC'D BY REGISTRAR
JAN 5 1968 | |
| 25b. REGISTRAR'S SIGNATURE
James Judge | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form. PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16648

16641

| | | | |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTO. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD. b. COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ESSEX | | c. LENGTH OF STAY IN 1b
03.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
27 KERRIA LANE | | d. STREET ADDRESS
27 KERRIA LANE | |
| 3. NAME OF DECEASED
(Type or print) SARAH S. RICHARDSON | | 4. DATE OF DEATH
Month DEC Day 16 Year 1967 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
AUG. 10, 1884 |
| 9. AGE (In years last birthday) yrs. 83 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
SAFRIGHT | | 14. MOTHER'S MAIDEN NAME
P | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
- | |
| 17. INFORMANT
DAVID RICHARDSON | | Address LANE 13 COUNTRY CLUB | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201 IMMEDIATE CAUSE (a) Acute Coronary Occlusion
DUE TO HCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 0
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Thos C Patterson M.D. | | 22. DATE SIGNED
12/18/67 | |
| EXAMINER'S NAME (Type)
THOS C PATTERSON | | 22b. REGISTRAR'S SIGNATURE
Charles Judge | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12/18/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
DAK LAWN | | 23d. LOCATION (City or Town) (County) (State)
BALTO. MD. | |
| 24. FUNERAL DIRECTOR
J.G. CONNELLY SONS | | 25a. REC'D BY REGISTRAR
300 MACE | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE DEC 20 1967 | |

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WILLIAM L. BROWN

Wm.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME
6M 1/64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Owings Mills</i> | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Owings Mills</i> 03-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>5 Pleasant Hill Road</i> | | e. STREET ADDRESS
<i>5 Pleasant Hill Road</i> | f. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
<i>Wylie L. Ritchey Sr.</i> | | 4. DATE OF DEATH
Month <i>December</i> , Day <i>1</i> , Year <i>1967</i> | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<i>August 8, 1905</i> |
| 9. AGE (In years last birthday)
<i>62</i> yrs. | | 10. IF UNDER 1 YEAR
Months <i>03</i> , Days <i>1</i> | 11. IF UNDER 24 HRS.
Hours <i>19</i> , Min. <i>67</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Lawyer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<i>Balto. City</i> |
| 12. CITIZEN OF WHAT COUNTRY
<i>USA</i> | | 13. FATHER'S NAME
<i>Michael W. Ritchey</i> | |
| 14. MOTHER'S MAIDEN NAME
<i>Bessie Laughlin</i> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<i>No</i> | |
| 16. SOCIAL SECURITY NO.
<i>214-38-9084</i> | | 17. INFORMANT
<i>Mr. Wylie L. Ritchey Jr.</i> Address <i>Owings Mills, Md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Angina Pectoris</i>
DUE TO (b) <i>Arteriosclerotic C-V Dis.</i>
DUE TO (c) <i>4202</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
<i>6 mo.</i>
<i>1 yr.</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
<i>none</i> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <i>none</i> p.m. <i>19</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<i>D. D. Caples</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
<i>D. D. Caples, M. D.</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED
<i>12-2-67</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | 23b. DATE THEREOF
<i>Dec. 4, 67</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>All Saints Cemetery</i> | 23d. LOCATION (City or Town) (County) (State)
<i>Reisterstown, Md.</i> |
| 24. FUNERAL DIRECTOR
<i>J. F. Eline & Sons</i> | | 25a. REC'D BY REGISTRAR
DATE <i>DEC 4 1967</i> | |
| ADDRESS
<i>Reisterstown, Md.</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

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WILSON, JAMES, JR., 1861

J. S. Taylor

Dec 1 1861

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|--|---|---|---------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 16650 | | 16643 | |
| CERTIFICATE OF DEATH | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rosedale Rural | | c. LENGTH OF STAY IN 1b
45 yrs | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1236 Spring Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) William A. Ritter | | 4. DATE OF DEATH
Month 12 Day 18 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cau | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-17-1881 |
| 9. AGE (In years lost birthday) yrs.
86 | | 10. IF UNDER 1 YEAR
Months 03 Days 11 Hours 00 Min. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William A. Ritter | | 14. MOTHER'S MAIDEN NAME
Martha McCullough | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-32-8381 | |
| 17. INFORMANT
Mrs Clara M. Ritter | | Address 1236 Spring Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
578X IMMEDIATE CAUSE (a) Acute Nontraumatic hemorrhage
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12/20 , 19 66 to 12/18 , 19 67 , that (I) (we) last saw the deceased alive on 12/17 , 19 67 , and that death occurred at 7:4 A.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John G. Orth, M.D. | | 22b. DATE SIGNED
12/19/67 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12-20-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Co. Md. | |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home | | 25a. REC'D BY REGISTRAR
DEC 22 1967 | |
| ADDRESS
7101 Belair Rd | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--------------------------------------|--|---|--|-----------------------------------|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 16651 | | | | | CERTIFICATE OF DEATH | | | 16644 | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | c. LENGTH OF STAY IN lb
42 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE - 21223 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | | d. STREET ADDRESS
212 N. GILMORE STREET | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
JAMES R. ROBINSON | | | | | 4. DATE OF DEATH Month Day Year
DECEMBER 12 19 67 | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
NEGRO | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1/5/09 | | 9. AGE (In years last birthday) yrs. 58
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
TRUCK DRIVER | | | 10b. KIND OF BUSINESS OR INDUSTRY
FUEL COMPANY | | 11. BIRTHPLACE (County & State, or foreign country)
WHITEHALL, MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CALVIN ROBINSON | | | | | 14. MOTHER'S MAIDEN NAME
GRACE DAVIS | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW II | | | 16. SOCIAL SECURITY NO.
203 01 11 43 | | 17. INFORMANT Address
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATIC COMA
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) CIRRHOSIS OF LIVER
DUE TO
(c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour "o.m. p.m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that he (this hospital) attended the deceased from 10/30/67 , 19__, to 12/12/67 19__, that he (we) last saw the deceased alive on 12/12/67 19__, and that death occurred at 10:30AM , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<i>John D. Talbert</i> | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED
12/12/67 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M. D. | | | | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12-15-67 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | |
| 24. FUNERAL DIRECTOR
MORTEN & DYETTE FUNERAL HOME | | | | | 25a. REC'D BY REGISTRAR
1701 LAURENS ST. BALTIMORE, MD 21201 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 16652 | | | |
| CERTIFICATE OF DEATH | | | |
| 16645 | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson
c. LENGTH OF STAY IN 1b
21206
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. JOSEPH HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21206
d. STREET ADDRESS
421 Bucks School House Rd.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Joseph Marshal ROHE | | 4. DATE OF DEATH
Month December Day 22 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
January 25, 1889 |
| 9. AGE (In years last birthday)
78 yrs | | 10. IF UNDER 1 YEAR
Months 7 Days 22 Hours 19 Min. 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Selfemployed | | 10b. KIND OF BUSINESS OR INDUSTRY
Store | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Rohe | | 14. MOTHER'S MAIDEN NAME
Ellen Dougherty | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-32-3191 | |
| 17. INFORMANT
Mr Joseph C. Rohe | | Address 21206 414 F. Shirley Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO
(b) coronary thrombosis secondary to coronary arteriosclerosis.
DUE TO
(c) arteriosclerosis. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that NO (this hospital) attended the deceased from 12/2/ , 19 67 , to 12/22/ , 19 67 that X (we) last saw the deceased alive on 12/22/ , 19 67 , and that death occurred at 9:55 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
William | | 22b. DATE SIGNED
M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 12/22/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Ines Cilliani, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12-26-1967 | 23c. NAME OF CEMETERY OR CREMATORY
St. Joseph's Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Co. Md. |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home 7401 Belair Road | | 25a. REC'D BY REGISTRAR
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25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| DATE DEC 27 1967 | | | |

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6800 Liberty Road</u> | | | | d. STREET ADDRESS <u>6800 Liberty Road</u> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>MILTON ROSEMAN</u> | | | | 4. DATE OF DEATH <u>DECEMBER 6 19 67</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 21, 1906</u> | |
| 9. AGE (In years lost birthday) <u>61</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comptroller</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Liquor</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>Aaron Roseman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Kaplan</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Lillian Roseman 6800 Liberty Rd</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of stomach, abdominal</u>
DUE TO <u>3 mo</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>Carcinoma of colon</u>
DUE TO <u>3 mo</u>
(c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Apr 11, 1959</u> to <u>Dec 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 4, 1967</u> , and that death occurred on <u>4:20 PM</u> , from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Dr. Irvin Sauber</u> | | | | 22b. DATE SIGNED <u>Dec 6, 67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Irvin Sauber</u> | | | | 22d. ADDRESS <u>6905 Park Heights Avenue</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12-8-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mikro Kodesh Beth Israel Baltimore, Maryland</u> | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. 6010 Reisterstown Rd.</u> | | | | 25a. REC'D BY REGISTRAR <u>DEC 12 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

14833

DEPARTMENT OF CLAIMS

1888

RECEIVED
JAN 10 1888
DEPARTMENT OF CLAIMS
WASHINGTON
D.C.

TO THE HONORABLE SECRETARY OF THE DEPARTMENT OF CLAIMS
WASHINGTON
D.C.

SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the claim of the late John A. Smith, deceased, for the sum of \$100.00, which was paid to him by the Government of the United States, and which was claimed by his estate.

The claim of the late John A. Smith, deceased, for the sum of \$100.00, which was paid to him by the Government of the United States, and which was claimed by his estate, is hereby acknowledged.

Very respectfully,
J. A. Smith

10-10-88

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|---|---------------------------|--|---------------------------------------|
| 16654 | | 16647 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton 03-1</u> | |
| c. LENGTH OF STAY IN 1b <u>71 yrs.</u> | | d. STREET ADDRESS <u>Cameron Mill Rd.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cameron Mill Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Harry</u> Middle <u>Rosier</u> Last <u>Rosier</u> | | 4. DATE OF DEATH
Month <u>12</u> - Day <u>26</u> Year <u>1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 12, 1896</u> |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Dorcas Ann Rosier</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>717-07-6768</u> | |
| 17. INFORMANT <u>Minnie Rosier</u> | | Address <u>Parkton, Md. R.D.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>A. S. C. V. Disease</u>
<u>4221</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>12/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , 19 <u>67</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>A. M. France</u> | | 22b. DATE SIGNED <u>12/28/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u> | | 22d. ADDRESS <u>PARKTON, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 23b. DATE THEREOF <u>12/29/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cem.</u> | | 23d. LOCATION (City, town or county) (State) <u>Freeland Md.</u> | |
| 24. FUNERAL DIRECTOR <u>S. Jacob Hartenstein</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| ADDRESS <u>New Freedom, Pa.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>JAN 2 1968</u> | | | |

1885

Walter

First Station

Amesbury, Mass.

Harry

M. W.

Trackman

Unknown

Railroad

Amesbury, Mass.

Thomas Ann Foster

THE CHURCH

Amesbury, Mass.

1885

Amesbury

Amesbury

Amesbury

Amesbury, Mass.

Amesbury, Mass.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and-2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16655

16648

| | | | |
|---|------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | c. LENGTH OF STAY IN lb
<u>38 yrs</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | d. STREET ADDRESS
<u>2 Catonsville, Md</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Spring Grove State Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Sohn</u> First <u>Henry</u> Middle <u>Rotenberg</u> Last | | 4. DATE OF DEATH
Month <u>12</u> Day <u>31</u> Year <u>1967</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9/16/98</u> |
| 9. AGE (In years last birthday)
<u>69</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>unemployed (Sexton)</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>St. Johns Cath. Church, Balto. Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>United States</u> | | 13. FATHER'S NAME
<u>Peter J. Rothenberger</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Mammie Stumpf</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT
<u>chart</u> Address <u> </u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4201</u> IMMEDIATE CAUSE (a) <u>pulmonary edema</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>probable repeated myocardial infarctions</u>
DUE TO
(c) <u>coronary insufficiency</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>chronic schizophrenia; mental retardation</u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<u>NO</u> | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | | 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a.m. <u> </u> p.m. <u>19</u> | |
| 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | |
| 20f. (City or town) (County) (State)
<u> </u> | | 21. I certify that (I) (this hospital) attended the deceased from <u>June 25, 1935</u> , to <u>12/31, 1967</u> , that (I) (we) last saw the deceased alive on <u>12/31, 1967</u> , and that death occurred at <u>1:08 AM</u> , from causes and on the date stated above. | |
| 22a. SIGNATURE
<u>Ann Louise Silver</u> | | 22b. DATE SIGNED
<u>12/31/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Ann Louise Silver, M.D.</u> | | 22d. ADDRESS
<u>Spring Grove State Hospital</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>1/3/68</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Cross Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Brooklyn, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Schimunek Funeral Home, Inc.</u>
<u>3331 Brehms Lane</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 3 1968</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

1883

STATE OF TEXAS

1883



Handwritten text, possibly a date or signature, including "1883" and "1884".

Handwritten text at the bottom of the page, possibly a signature or date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

90

MEDICAL CERTIFICATION

OR

1

M

16656

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16649

| | | | | | | | |
|--|---|---|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>—</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN 1b
<u>1 yr 3 1/2 mos</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> 30-4 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>FOREST HAVEN NURS Home 315 Ingleside Ave</u> | | | | d. STREET ADDRESS
<u>514 Old Orchard Rd</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>ETHEL</u> Middle <u>L.</u> Last <u>Rowan</u> | | | | 4. DATE OF DEATH
Month <u>12</u> Day <u>14</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3-13-93</u> | 9. AGE (In years last birthday) yrs.
<u>74</u> | IF UNDER 1 YEAR
Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>John Doyle</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Nellie Shelley</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>494-18-2581</u> | | 17. INFORMANT
Address <u>Mrs Mahala A. Rowan 514 Old Orchard</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<u>420.1</u> IMMEDIATE CAUSE (a) <u>Myocardial INFARCTION</u>
DUE TO (b) <u>Arterio-sclerotic changes - UNCLINICAL</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Arteriosclerosis - CLINICAL</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour <u>—</u> o.m. <u>—</u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> , 19 <u>66</u> , to <u>12/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> , 19 <u>67</u> , and that death occurred at <u>7 A.M.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>John H. Shaw M.D.</u> | | | | 22b. DATE SIGNED
<u>12/18/67</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>John H. Shaw M.D.</u> | |
| 22d. ADDRESS
<u>5800 Edmonson Ave Baltimore, Md.</u> | | | | 22e. REC'D BY REGISTRAR
DATE <u>DEC 18 1967</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Dec 16, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Lorraine Park Cemt.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> | | |
| 24. FUNERAL DIRECTOR
<u>STERLING FUNERAL ESTATE</u> | | | | 25a. ADDRESS
<u>736 Edm. Av Catonsville</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
PIKESVILLE | | c. LENGTH OF STAY IN 1b
20-4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MILFORD MANOR NURSING HOME | | d. STREET ADDRESS
3008 FALLSTAFF MANOR CT. | |
| 3. NAME OF DECEASED (Type or print)
First ISRAEL Middle RUCK Last DECEMBER | | 4. DATE OF DEATH
Month 24 Day 19 Year 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JUNE 10, 1892 |
| 9. AGE (In years last birthday)
75 yrs. | | 10. IF UNDER 1 YEAR
Months 24 Days 19 Hours 67 Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
GROCERY | | 11b. KIND OF BUSINESS OR INDUSTRY
RETIRED | |
| 11. BIRTHPLACE (County & State, or foreign country)
POLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
UNKNOWN | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
216-28-7002 | |
| 17. INFORMANT
MRS. ROSE RUCK, 3008 FALLSTAFF MANOR CT. #9 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
157X IMMEDIATE CAUSE (a) Carcinoma of pancreas
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | INTERVAL BETWEEN ONSET AND DEATH
6 months | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from June 1, 1966 , to Dec 24, 1967 , that (I) (we) saw the deceased alive on Dec 24, 1967 , and that death occurred at 11A M, from causes and on the date stated above | | | |
| 22a. SIGNATURE
Manuel Levin | | 22b. DATE SIGNED
12/24/67 | |
| 22c. PHYSICIAN'S NAME (Type)
MANUEL LEVIN M.D. | | 22d. ADDRESS
1101 PARK HEIGHTS AVE BALTO MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
12-26-67 | 23c. NAME OF CEMETERY OR CREMATORY
CHIZUK AMUNO | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | 25a. REC'D BY REGISTRAR
DATE DEC 28 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles J. Jager | | | |

1665

REPUBLIC OF PERU

1665

CONSTITUTION

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16658

CERTIFICATE OF DEATH

16651

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | |
| c. LENGTH OF STAY IN 1b | | | | d. STREET ADDRESS <u>6109 Park Heights Ave</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, write street address) <u>6109 Park Heights Manor</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>BARNETT</u> Middle <u>H.</u> Last <u>RUDO</u> | | | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>31</u> Year <u>1967</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>JULY 15, 1884</u> | |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>HYMAN Rudo</u> | | | | 14. MOTHER'S MAIDEN NAME <u>REBECCA ? One</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs Elsie Rudo - 6109 Park Hts</u> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u>
DUE TO
(b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>
DUE TO
(c) <u>4221</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Immediate</u>
<u>YEARS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>AZOTEMIA</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>67</u> , to <u>31 Dec</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>30 Dec</u> , 19 <u>67</u> , and that death occurred at <u>2:00</u> AM, from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <u>Malcolm S Druskin</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>31 Dec 67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>MALCOLM S. DRUSKIN, MD</u> | | | | 22d. ADDRESS <u>2217 SOUTH ROAD, BALTO 9, MD</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Jan 2/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Hebrew</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md</u> | |
| 24. FUNERAL DIRECTOR <u>Sol Leuner & Son Inc - 60010 Kent. Road</u> ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>Jan 4 1968</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1885

1885

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16659

CERTIFICATE OF DEATH

16652

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Baltimore</u>
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE <u>Maryland</u>
b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson 4</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore 21213</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>St. Joseph Hospital</u> | | d. STREET ADDRESS
<u>3423 Ramona Avenue</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>AMANDA RUNDBERG</u> | | 4. DATE OF DEATH <u>December 16, 1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>August 17, 1897</u> |
| 9. AGE (In years last birthday)
<u>70</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>at home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Sweden</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>August Larson</u> | | 14. MOTHER'S MAIDEN NAME
<u>unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>551-28-9370B</u> | | 16. SOCIAL SECURITY NO.
<u>551-28-9370B</u> | |
| 17. INFORMANT
<u>Fred Rundberg, son</u> | | Address
<u>5616 Ready Ave.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4221</u> IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO
(c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that he (this hospital) attended the deceased from <u>December 9, 1967</u> , to <u>December 16, 1967</u> that he (we) last saw the deceased alive on <u>December 16, 1967</u> , and that death occurred at <u>7:30 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Antonio De Leon</u> | | 22b. DATE SIGNED
<u>December 16, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Antonio De Leon, M. D.</u> | | 22d. ADDRESS
<u>7620 York Road, Towson 4, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>12/19/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gardens of Faith Cem.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Schimunek Funeral Home, Inc.</u>
3331 Brehms Lane | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 21 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 8 Film G-396 1/2/68 18r
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16660

16653

| | | | | | |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| | | | | Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | | d. STREET ADDRESS
528 Walker Avenue, 21212 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) JOSEPH FRANCIS SADUSK, SR. | | | 4. DATE OF DEATH
Month December Day 16 Year 19 67 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
12-28-86 85 | | 9. AGE (In years last birthday) yrs. 81 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Tailor | | 11. BIRTHPLACE (State or foreign country)
Lithuania | |
| 13. FATHER'S NAME
Francis Sadusk | | | 14. MOTHER'S MAIDEN NAME
Unknown | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
213-09-5608 | | 17. INFORMANT
Wife - Eva M. Address same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest INTERVAL BETWEEN ONSET AND DEATH Sudden
DUE TO Shock Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Multiple Fractures and Internal Injuries Sudden | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)
Struck by Automobile Family Transmission Not M.E. Code | | | |
| 20c. TIME OF INJURY Month, Day, Year
12-16 1967 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Street | |
| | | | | 20f. (City or town) (County) (State)
Baltimore City Maryland | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Charles F. O'Donnell M.D. | | | 22. DATE SIGNED
12/16/67 | | |
| EXAMINER'S NAME (Type)
Charles F. O'Donnell, M.D. | | | Address (Street, city, town, or county) | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/20/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | |
| | | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore | |
| 24. FUNERAL DIRECTOR
Mitchell Wiedefeld Home-6500 York Road-21212 | | | 25a. REC'D BY REGISTRAR
DATE DEC 29 1967 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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CERTIFICATE OF DEATH

16662

16655

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| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>STEVENSON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>STEVENSON</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>VILLA JULIE</u> | | d. STREET ADDRESS
<u>VALLEY ROAD.</u> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>SISTER ELIZABETH ST. PETER</u> | | 4. DATE OF DEATH
Month Day Year
<u>DEC. 15, 1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
<u>JULY 12, 1883</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>TEACHER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>RELIGIOUS</u> | 9. AGE (In years last birthday)
<u>84</u> yrs. |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>IRELAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>PETER MCGIRR</u> | | 14. MOTHER'S MAIDEN NAME
<u>ELIZABETH QUINN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>_____</u> | |
| 17. INFORMANT
<u>Sister Bernard Marie - Villa Julie</u> | | Address
<u>_____</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Accident.</u>
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>arteriosclerotic vascular disease</u>
DUE TO
(c) <u>_____</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>48 hr</u>
<u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> , 1963, to <u>Dec 15</u> , 1967, that (I) (we) last saw the deceased alive on <u>Nov 14 1967</u> , and that death occurred at <u>1230 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Harold H Burns</u> | | 22b. DATE SIGNED
<u>12-15-1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>8106 Hays Rd.</u> | | 22d. ADDRESS
<u>_____</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
<u>12-18-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Trinity Convent and</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Beltsville Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Tracy - Conway & Son, Baltimore, Md.</u> | | 25a. REC'D BY REGISTRAR
<u>DEC 26 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>John J. Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|---|--|
| 16661 | | 16654 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Ruxton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Ruxton</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>6509 Darnell Rd.</u> | | d. STREET ADDRESS
<u>6509 Darnell Rd.</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>James Mumford Sawhill</u> | | 4. DATE OF DEATH
Month <u>December</u> Day <u>22</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
<u>April 7, 1905</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Vice President</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Alloy Cladding Co.</u> | 9. AGE (In years last birthday) yrs. <u>62</u> |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>James E. Sawhill</u> | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Moore</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>284-07-4452</u> | |
| 17. INFORMANT
<u>Mrs. Mary G. Sawhill</u> | | Address
<u>Same</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>Coronary arteriosclerosis</u>
DUE TO
(c) <u>1 min</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 3, 1947</u> to <u>December 22, 1967</u> that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above. | | 22a. SIGNATURE
<u>Charles Holmes Boyd</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. C. Holmes Boyd</u> | | 22b. DATE SIGNED | |
| 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>12-26-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Druid Ridge</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Pikesville, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212</u> | | 25a. REC'D BY REGISTRAR
DATE <u>3 1968</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. J...</u> | |

10020

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16663

CERTIFICATE OF DEATH

16656

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson 4
c. LENGTH OF STAY IN 1b | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore-21234
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
031 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
1918 Wildwood Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
ALBERT SCHAEBLE
First Middle Last | | 4. DATE OF DEATH
December 2, 1967
Month Day Year | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
November 27, 1881 |
| 9. AGE (In years last birthday) yrs.
86 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bookkeeper | | 10b. KIND OF BUSINESS OR INDUSTRY
Office | |
| 11. BIRTHPLACE (County & State, or foreign country)
Brooklyn, New York | | 12. CITIZEN OF WHAT COUNTRY?
U.S. A. | |
| 13. FATHER'S NAME
Henry Schaible | | 14. MOTHER'S MAIDEN NAME
Dora ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-12-0800 | |
| 17. INFORMANT
Mrs. Florence Schaible | | Address
Above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
293X
IMMEDIATE CAUSE (a) Heart failure
DUE TO (b) Anemia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that he (this hospital) attended the deceased from November 24, 1967 , to December 2, 1967 , that he (we) last saw the deceased alive on December 2, 1967 , and that death occurred at 9:10 a.m. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
William
M.D. | | 22b. DATE SIGNED
December 2, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Inez Gilliani, M.D. | | 22d. ADDRESS
7620 York Road, Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12-5-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | 23d. LOCATION (City or Town) (County) (State)
Parkville Balto. Md. | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | | 25a. REC'D BY REGISTRAR
DEC 5 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

1868

STATE OF OHIO

1868

Dec 5 1868

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16664

16657

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore-Catonsville</u> | | c. LENGTH OF STAY IN 1b <u>15 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u> | | d. STREET ADDRESS <u>1120 Ingleside Ave</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Charles</u> Middle <u>A.</u> Last <u>Schaum</u> | | 4. DATE OF DEATH
Month <u>12</u> Day <u>31</u> Year <u>1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/7/84</u> |
| 9. AGE (In years lost birthday) <u>83</u> yrs. | | IF UNDER 1 YEAR
Months <u>03</u> Days <u>1</u> | IF UNDER 24 HRS.
Hours <u>03</u> Min. <u>1</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CONFECTION</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> |
| 13. FATHER'S NAME <u>Jacob Schaum</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine</u> | |
| 16. SOCIAL SECURITY NO. <u>213-03-5801</u> | | 17. INFORMANT <u>chart</u> Address <u>SPRING GROVE ST. HOSPITAL</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac ischemia</u>
DUE TO <u>4201</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>pneumonia</u>
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>3 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Diabetes mellitus - adult onset; chronic brain syndrome</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 16, 1967</u> to <u>Dec 31, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 30, 1967</u> , and that death occurred at <u>4:45 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Ann Louise Silver</u> | | 22b. DATE SIGNED <u>12/31/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Ann Louise Silver, M.D.</u> | | 22d. ADDRESS <u>Spring Grove State Hospital</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>1-3-1968</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u> | 23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MARYLAND</u> |
| 24. FUNERAL DIRECTOR <u>WEBER FUNERAL HOME 5311 EDMONDSON AVE</u> | | 25a. REC'D BY REGISTRAR <u>JAN 2 1968</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

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Ann Louise Silver, H.D.

Ann Louise Silver, H.D.

Ann Louise Silver, H.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16665

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16658

| | | | | | | | | | | | | | |
|---|--|---------------------|---|---------------------------------------|---|---|---|---|--|--------------------------------|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Elizabeth</i> First Middle Last <i>Schneider</i> | | | 2a. DATE OF DEATH
Month <i>12</i> Day <i>22</i> Year <i>67</i> | | | 2b. HOUR
<i>3:45 AM</i> | | | | | | | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
<i>Apr. 6, 87</i> | | 6. AGE (In years
lost birthday) <i>80</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign
country) <i>Balto</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Balto</i> Md. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Balto Md</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) <i>1330 Harford Hill Rd</i> | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>Md</i> | | | 13b. COUNTY
<i>Balto</i> | | 13c. CITY OR TOWN
<i>Balto</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>1330 Harford Hill Rd</i> | | | | |
| 14. FATHER'S NAME
First <i>Carl</i> Middle <i>Wilhelm</i> Last | | | 15. MOTHER'S MAIDEN NAME
First <i>Emma</i> Middle <i>?</i> Last | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO.
<i>1</i> (If yes give war or dates of service) | | | | |
| 17. INFORMANT
<i>Daughter</i> | | | Address
<i>Same</i> | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinoma of the face (epidermal) with</i>
<i>1970</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) <i>metastases to neck + chest</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>2 years</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>December, 1957</i> to <i>Dec 22</i> , 19 <i>67</i> , that (I) (we) last
saw the deceased alive on <i>Dec 22</i> , 19 <i>67</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Stellman</i> | | | | | | DEGREE ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | | | | 22e. ADDRESS
<i>6217 Harford Rd Baltimore Md</i> | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE
<i>12/23/67</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Eastwood</i> | | | 23d. LOCATION (City or Town)
<i>Balto Md</i> | | (County) (State) | | | |
| 24. FUNERAL DIRECTOR
<i>H. Beermann</i> | | | | | | ADDRESS
<i>6067 Harf Rd</i> | | | 25a. REC'D BY REGISTRAR
DATE <i>DEC 27 1967</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Francis Judge</i> | |

16687



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MEDICAL CERTIFICATION

| | | | |
|---|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN lb
122 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | d. STREET ADDRESS
1316 E Fort Avenue | |
| 3. NAME OF DECEASED
(Type or print)
JOHN | | 4. DATE OF DEATH
Month December Day 14 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/6/09 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Stevodore | | 9b. KIND OF BUSINESS OR INDUSTRY
Shipping | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Stevodore | | 10b. KIND OF BUSINESS OR INDUSTRY
Shipping | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Martin Schnuit | | 14. MOTHER'S MAIDEN NAME
Wilhelmina Picker | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW-11 | | 16. SOCIAL SECURITY NO.
217 05 89 86 | |
| 17. INFORMANT
Clinical Rcds, VA Hospital, Fort Howard Md. | | 18. ADDRESS
Clinical Rcds, VA Hospital, Fort Howard Md. | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) THROMBOSIS, RIGHT MIDDLE CEREBRAL ARTERY
DUE TO (b) CEREBRAL ARTERIOSCLEROSIS
DUE TO (c) 332X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
unk | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
AMYOTROPHIC LATERAL SCLEROSIS | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from Aug. 14, 1967 to Dec. 14, 1967 that (X) (we) last saw the deceased alive on Dec. 14, 1967 , and that death occurred at 8:55 a.m. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
J. D. Talbert | | 22b. DATE SIGNED
12/14/67 | |
| 22c. PHYSICIAN'S NAME (Type)
J. D. TALBERT, M.D. | | 22d. ADDRESS
VA Hospital, Fort Howard, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/18/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
Charles L. Stevens, Inc. | | 25a. REC'D BY REGISTRAR
DEC 19 1967 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | DATE | |

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16667

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Maryland Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>—</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Pikesville</u> | | c. LENGTH OF STAY IN TB
<u>—</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Melford Manor Nursing Home</u> | | d. STREET ADDRESS
<u>1701 Eutaw Place</u> | |
| 3. NAME OF DECEASED
(Type or print)
<u>Dora Oppenheimer Schorsch</u> | | 4. DATE OF DEATH
Month <u>Dec</u> Day <u>10</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan 26, 1875</u> |
| 9. AGE (In years last birthday)
<u>92</u> yrs. | | IF UNDER 1 YEAR
Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>at home</u> | |
| 11. BIRTH PLACE (County & State, or foreign country)
<u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Isch Oppenheimer</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lo Anna?</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>26-46-0984</u> | |
| 17. INFORMANT
<u>Mrs Henry Miller</u> | | Address
<u>7703 Ardland Rd</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Vascular Accident</u>
DUE TO <u>260X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Diabetic Mellitus - Hypertension C.V.D</u>
DUE TO <u>—</u>
(c) <u>Cardiac Insuff.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>—</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> , 19 <u>65</u> , to <u>Dec 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 9</u> , 19 <u>67</u> , and that death occurred at <u>5H</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Bernard Cohen</u> | | 22b. DATE SIGNED
<u>12-11-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>BERNARD COHEN</u> | | 22d. ADDRESS
<u>3501 ST PAUL STREET</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Dec 11/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Hai Sinai</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md</u> | |
| 24. FUNERAL DIRECTOR
<u>Sol Levinson & Bros. 6010 Reisterstown Rd.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 12 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

CERTIFICATE OF DEATH

16668

16661

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Halethorpe
c. LENGTH OF STAY IN 1b
50 ?
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
5700 Second Avenue | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)
Maryland
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Halethorpe 21227
d. STREET ADDRESS
5700 Second Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
JOHN GEORGE SCHROEDER | | | | 4. DATE OF DEATH
Month Day Year
December 13, 1967 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-14-1879 | |
| 9. AGE (In years last birthday)
87 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Post Office | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. of America | |
| 13. FATHER'S NAME
Not known George Schroeder | | | | 14. MOTHER'S MAIDEN NAME
Not known Luise Volland | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
Spanish & Amer. 220-44-5482 | | 17. INFORMANT
Address
Mrs. Marion D. B. Schroeder - 5700 Second Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic myocarditis with decompensation
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Hypertension
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
8 yrs.

yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1955 to Dec. 13, 1967 that (I) (we) last saw the deceased alive on Dec. 11, 1967 , and that death occurred 12:30 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Frederic V. Beitler M. D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
12-13-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Frederic V. Beitler M. D. | | | | 22d. ADDRESS
1014 Francis Avenue | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12-15-67 | | 23c. NAME OF BURIAL OR CREMATORY
National Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
HENRY SANDER & SONS INC.
BALTIMORE MARYLAND | | | | 25a. REC'D BY REGISTRAR
DEC 19 1967
DATE
25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Journal of Interpersonal Violence

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

Journal of Interpersonal Violence

1997-1998 1999-2000

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16662

VR A15 (4)
20 M 1/66

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14881

EXHIBIT OF DEED

14881

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14881

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
20 M 1/66

166670

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16663

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore 21236
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. 21236 b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Overlea | | c. LENGTH OF STAY IN lb
Overlea | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
206 Sipple Ave. | | d. STREET ADDRESS
206 Sipple Ave. | |
| 3. NAME OF DECEASED (Type or print)
First GERTRUDE Middle LAKE Last SCHULZE | | 4. DATE OF DEATH
Month December Day 3 Year 19 67 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 4, 1895 |
| 9. AGE (In years last birthday) yrs.
72 | | 10. IF UNDER 1 YEAR
Months 72 Days 03 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
at home | |
| 11. BIRTHPLACE (County & State, or foreign country)
Cambridge, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Hooper Smith | | 14. MOTHER'S MAIDEN NAME
unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
212-46-9649 | | 16. SOCIAL SECURITY NO.
William E. Schulze, son, above | |
| 17. INFORMANT
Address | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
172x IMMEDIATE CAUSE (a) Cervicocarcinoma of the Endometrium
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | |
| 19. INTERVAL BETWEEN ONSET AND DEATH
1 year | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug , 19 66 , to Dec , 19 67 , that (I) (we) last saw the deceased alive on 3 Dec , 19 67 , and that death occurred at 9:07 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
George H. Miller | | 22b. DATE SIGNED
12/4/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. George Miller | | 22d. ADDRESS
6411 Belair Road | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/7/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | 23d. LOCATION (City or Town) (County) (State)
Glen Burnie, Md. | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane | | 25a. REC'D BY REGISTRAR
DATE DEC 7 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

1988

STATE OF TEXAS

1988

Blank form with faint horizontal lines and a large, faint circular stamp in the center.

CERTIFICATE OF DEATH

16671

16664

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore county, MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Magothy Beach b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Arbustus | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Pasadena, Maryland |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Stanley Ankudas, MD. (Office) | | d. STREET ADDRESS
Box #277 | |
| 3. NAME OF DECEASED
(Type or print) Mr. Edgar Leo Sears | | 4. DATE OF DEATH
Month 12 Day 8 Year 1967 | |
| 5. SEX
male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
22 Sept. 1920 |
| 9. AGE (In years last birthday)
47 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Interior Decorator | | 10b. KIND OF BUSINESS OR
Krownstein, Co. Inc. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Lansdown, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Jessie W. Sears | | 14. MOTHER'S MAIDEN NAME
Mary V. Jackson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
yes WW II | | 16. SOCIAL SECURITY NO.
218009-6350 | |
| 17. INFORMANT
L. Alberta Sears - Wife | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive myocardial infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12-8-67 , to 12-8-67 , that (I) (we) last saw the deceased alive on 12-8-67 , and that death occurred at 3:20 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Stanley Ankudas | | 22b. DATE SIGNED
12/9/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Stanley Ankudas, M.D. | | 22d. ADDRESS
1101 Maiden Choice Lane #21229 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
12 Dec. 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Nat'l. Cem. | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
Singleton Funeral Home/Glen Burnie, Md. | | 25a. REC'D BY REGISTRAR
DATE DEC 11 1967 | |
| 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Jackson

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

16672

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16665

| | | | | | | | |
|---|---------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Towson | | | | c. LENGTH OF STAY IN 1b
20 yrs. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Mission Helpers Of The Sacred Heart Convent | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Sister M. Immaculata (Katherine Shea) | | | | 4. DATE OF DEATH
Month Day Year
Dec. 31 1967 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
Cau. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 5, 1877 | 9. AGE (In years last birthday)
90 | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Nun | | 10b. KIND OF BUSINESS OR INDUSTRY
Convent | | 11. BIRTHPLACE (County & State, or foreign country)
Fishersgraig, Ireland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Martin Shea | | | | 14. MOTHER'S MAIDEN NAME
Catherine Byrne | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Address
Convent Records, 1001 W. Joppa Rd. Towson | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 442X
DUE TO Coronary Atherosclerosis
(b) Coronary Artery Disease
DUE TO Coronary Artery Disease
(c) Coronary Artery Disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1/7, 1950 , to 12/31, 1967 , that (I) had last saw the deceased alive on 12/22, 1967 , and that death occurred at M , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Charles F. O'Donnell | | | | 22b. DATE SIGNED
1/2/1968 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Charles F. O'Donnell, M.D. | | | | 22d. ADDRESS
7501 York Road | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Jan. 3, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Convent Cemetery | | 23d. LOCATION (City, town or county) (State)
1001 W. Joppa Rd. Towson, Md. | |
| 24. FUNERAL DIRECTOR
B. Vernon Gennin | | | | 25a. REC'D BY REGISTRAR
JAN 3 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

STATE DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
WASHINGTON, D. C.
1957

Division of Animal Industry
Bureau of Veterinary Medicine
Washington, D. C.
1957

Division of Animal Industry
Bureau of Veterinary Medicine
Washington, D. C.
1957

Division of Animal Industry
Bureau of Veterinary Medicine
Washington, D. C.
1957

Division of Animal Industry
Bureau of Veterinary Medicine
Washington, D. C.
1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|---|--|------------------------------|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 16667 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Ridgeway Manor Nursing Home | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
121 Dennison Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First Juliana Middle Shuck Last Shuck | | | | | 4. DATE OF DEATH
Month December Day 17 Year 1967 | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Sept. 22, 1867 | | 9. AGE (In years last birthday)
100 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME
John Morissey | | | | | 14. MOTHER'S MAIDEN NAME
Amanda Clark | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
None | | 16. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Mrs. Sarah Matessa 56 Mapledale Ave. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 day |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1 Jan , 19 66 , to 17 Dec , 19 67 , that (I) (we) last saw the deceased alive on 16 Dec , 19 67 , and that death occurred at 2 P M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
William Goodman | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
17 Dec 67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
WILLIAM GOODMAN | | | | 22d. ADDRESS
1331 Sulphur Spring Rd 2122 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/21/67 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Patricks Cemetery | | 23d. LOCATION (City, town or county) (State)
Cumberland, Md. | | | |
| 24. FUNERAL DIRECTOR
Wm F. Tichner & Sons | | | | ADDRESS
Baltimore, Md. | | 25a. REC'D BY REGISTRAR
DEC 21 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16674

16668

| | | | | | | | |
|--|----------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | c. LENGTH OF STAY IN 1b
60 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
10 CLOVER AVENUE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First AUGUST Middle LOUIS Last SIMON | | | | 4. DATE OF DEATH
Month DECEMBER Day 16 Year 19 67 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/4/10 | | 9. AGE (In years last birthday)
57 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY
STEEL | | 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MD | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN LOUIS SIMON | | | | 14. MOTHER'S MAIDEN NAME
MARY ANN KOESTER | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) YES WWII | | 16. SOCIAL SECURITY NO.
313 07 5673 | | 17. INFORMANT
Address
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CANCER OF PANCREAS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO
(b) _____
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
MONTHS | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/16/67 , 19____, to 12/16/67 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/16/67 19____, and that death occurred at 4:20AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>George Dudas</i> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
12 16 67 | |
| 22c. PHYSICIAN'S NAME (Type)
GEORGE DUDAS, MD | | | | 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12- 20-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Zion Luth. Church Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home | | | | 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |
| 25c. ADDRESS
7401 Belair Rd.
Baltimore, Md. 21236 | | | | DATE DEC 20 1967 | | | |

1887

STATE OF MARYLAND

1888

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|-----------------------------------|--------------------|---------------|
| BALTIMORE | MARYLAND | BALTIMORE |
| PORT HOWARD | 60 DAYS | BALTIMORE |
| NATIONALS ADMINISTRATION HOSPITAL | 10 CLOVER AVENUE | |
| AUGUST | LOUIS | SIMON |
| MALE | WHITE | 27 |
| LABORER | STEEL | BALTIMORE, MD |
| JOHN LOUIS SIMON | MARY ANN ROBERTS | |
| YES | ALL | 913 07 2473 |
| | CANCER OR PANCREAS | |

| | | |
|------------------|------------------------------------|-------------|
| 12/16/07 | 10/16/07 | 12/16/07 |
| GEORGE DUDAS, MD | VA HOSPITAL, PORT HOWARD, MARYLAND | XI 12 16 07 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|---------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>-</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | c. LENGTH OF STAY IN 1b
<u>30.4</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Chesapeake Manor N. H.</u> | | d. STREET ADDRESS
<u>116 W. University Pkwy.</u> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Lelia</u> Middle <u>I</u> Last <u>Sinclair</u> | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>16</u> Year <u>1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1-8-1874</u> |
| 9. AGE (In years last birthday)
<u>93</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>16</u> Days <u>19</u> Hours <u>67</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Arthur Sinclair</u> | | 14. MOTHER'S MAIDEN NAME
<u>Drusilla Willitt</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>--</u> | |
| 17. INFORMANT
<u>Talbot Sinclair</u> | | Address
<u>Hyattsville, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4200</u> <u>ARTERIO-SCLEROTIC HEART DISEASE</u>
DUE TO (b) <u>2 DAYS</u>
DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY Month, Day, Year
Hour <u>a.m.</u> <u>19</u> p.m. | |
| 20c. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20e. (City or town) (County) (State) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER</u> , 19 <u>64</u> , to <u>DEC 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>DEC 15</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>John M. Scott</u> | | 22b. DATE SIGNED
<u>DEC 16, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JOHN M. SCOTT</u> | | 22d. ADDRESS
<u>600 W. BELVEDERE AVE, BALTIMORE 21210</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>12-18-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Greenmount</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>H.W. Jenkins & Sons Co. 4905 York Rd., Balto., Md.</u> | | 25a. REC'D BY REGISTRAR
<u>DEC 19 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

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CENTRAL OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 16676 | | CERTIFICATE OF DEATH | |
| 16670 | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
1005 Sayward Avenue | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
Baltimore, Maryland 21234 | |
| 3. NAME OF DECEASED
(Type or print)
First ELIZABETH Middle M. Last SMALLWOOD | | 4. DATE OF DEATH
Month December Day 23 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-29-82 |
| 9. AGE (In years last birthday) 85 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
West Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John E Mantz | | 14. MOTHER'S MAIDEN NAME
Margaret | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-18-7601 | |
| 17. INFORMANT
Nephew - Byron Barton | | Address
same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable cardiac failure
DUE TO
(b) Mitral insufficiency
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Marked emaciation | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that he (this hospital) attended the deceased from 12-23- , 19 67 , to 12-23 , 19 67 , that he (we) last saw the deceased alive on 12-23 , 19 67 , and that death occurred at 12-23 , 19 67 , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Samuel Lee | | 22b. DATE SIGNED
12/24/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Samuel Lee, M.D. | | 22d. ADDRESS
7620 York Rd. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12/23/67 | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland |
| 24. FUNERAL DIRECTOR
Leonard J Ruck Inc. 5305 Harford Rd | | 25a. REC'D BY REGISTRAR
DEC 27 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1958

CONFIDENTIAL

1958



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> | | | | | | | | | | | | c. LENGTH OF STAY IN b. <u>3 Weeks</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baltimore Co. General Hospital</u> | | | | | | | | | | | | d. STREET ADDRESS <u>3416 Chapman Rd.</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>E</u> Last <u>Smith</u> | | | | | | | | | | | | DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>1967</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. SEX <u>M</u> | | | | 6. COLOR OR RACE <u>W</u> | | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH <u>9-7-83</u> | | | | 9. AGE (In years last birthday) <u>84</u> yrs. | | | | IF UNDER 1 YEAR Months Days | | | | IF UNDER 24 HRS. Hours Min. | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | | | | | | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u> | | | | | | | | | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>ARKANSAS</u> | | | | | | | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | | | | | |
| 13. FATHER'S NAME <u>Unk.</u> | | | | | | | | | | | | 14. MOTHER'S MAIDEN NAME <u>Unk.</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | | | | | | | | | 16. SOCIAL SECURITY NO. <u>431-68-8661</u> | | | | | | | | | | | | 17. INFORMANT Address <u>Mrs. Irene Holcomb - Randallstown, Md.</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>5411 POSS. Pulm. Infection</u>
DUE TO (b) <u>Post operative (Bleeding Dysentery ulcer perforation spontaneous color)</u>
DUE TO (c) <u>spontaneous</u> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u> | | | | | | | | | | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | | | | | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11-9-67</u> to <u>12-12-67</u> , that (I) (we) last saw the deceased alive on <u>12-12-67</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Andberto B. Flores M.D.</u> | | | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | 22b. DATE SIGNED <u>12-12-67</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>ANDBERTO P. FLORES</u> | | | | | | | | | | | | 22d. ADDRESS <u>3502 W. Rogers Ave.</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | | | | | | | | | 23b. DATE THEREOF <u>12-16-67</u> | | | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Bentonville Cemetery</u> | | | | | | | | | | | | 23d. LOCATION (City, town or county) (State) <u>Bentonville, ARK.</u> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u> | | | | | | | | | | | | ADDRESS <u>Hydenville, Md.</u> | | | | | | | | | | | | 25a. REC'D BY REGISTRAR <u>DEC 15 1967</u> | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u> | | | | | | | | | | | |

1901

1901

CERTIFICATE OF DEATH

Blank form with faint horizontal lines and illegible text impressions.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|---|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 16672 | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mount Wilson | | c. LENGTH OF STAY IN 1b
1 mo. 20 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hampstead Manchester | | d. STREET ADDRESS
107 N. Main St. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Mount Wilson State Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
EMORY HOLLICE SMITH | | 4. DATE OF DEATH
Month Day Year
12 / 14 / 19 67 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/18/1896 |
| 9. AGE (In years last birthday)
71 yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
store clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | |
| 11. BIRTHPLACE (County & State, or foreign country)
Hampstead, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Smith. | | 14. MOTHER'S MAIDEN NAME
Iola Snider | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
220-07-9742 | |
| 17. INFORMANT
Address
Records, Mount Wilson State Hosp. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 527.2
DUE TO Cor pulmonale
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) chronic obstructive pulmonary disease
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 10/25/1967 , to 12/14/1967 that (I) (we) last saw the deceased alive on 12/14/1967 , and that death occurred at 11:55 P.M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
W. Newcomer | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Wm. Newcomer, M.D., Superintendent | | 22d. ADDRESS
Mount Wilson, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Dec. 17, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Manchester Cemetery | 23d. LOCATION (City or Town) (County) (State)
Manchester, Md. |
| 24. FUNERAL DIRECTOR
ADDRESS
Tipton - Eline Funeral Home Hampstead, Md. | | 25a. REC'D BY REGISTRAR
DATE
DEC 18 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1861

1861

DEPARTMENT OF DEATH

Baltimore

Mount Wilson

Mount Wilson State Hospital

Female

W

Age 20

Long Island

Mount Wilson State Hosp.

W. H. Hecox, M.D., Superintendent Mount Wilson, Maryland

Printed - This Form is for use only

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16679

CERTIFICATE OF DEATH

16673

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland b. COUNTY
Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Garrison | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reisterstown | |
| c. LENGTH OF STAY IN IS
10 weeks | | d. STREET ADDRESS
Berrymans Lane | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Foxleigh Nursing Home | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
John William Smith | | 4. DATE OF DEATH
Month Day Year
Dec. 16 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 25, 1884 |
| 9. AGE (In years at birthday)
83 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dye worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Textile Ind. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore Co., Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Albert Smith | | 14. MOTHER'S MAIDEN NAME
Ella Lee | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-10-6743 | |
| 17. INFORMANT
Mrs. Ruth Redifer | | Address
Berrymans Lane Reisterstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
DUE TO (b) Arteriosclerosis - generalized
DUE TO (c) years | | INTERVAL BETWEEN ONSET AND DEATH
1 month | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from August 1967 to December 16, 1967 that (I) (we) lost saw the deceased alive on December 15, 1967 , and that death occurred at 6:00 PM , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Clarence E. McWilliams | | 22b. DATE SIGNED
12-17-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Clarence E. McWilliams M.D. | | 22d. ADDRESS
11904 Reisterstown Rd Reisterstown Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Dec. 19, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Saters Baptist Cem. | 23d. LOCATION (City or town) (County) (State)
Baltimore Co., Md. |
| 24. FUNERAL DIRECTOR
H. J. Schhardt | | 25a. REC'D BY REGISTRAR
DATE
DEC 20 1967 | |
| ADDRESS
Owings Mills, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1887

Belgium

Carleton

to work

Belgium

Belgium

Belgium

John William Smith

Dec. 18

April 25, 1887

John William Smith

to work

Belgium

Belgium

George Albert Smith

Elia Lee

No

Belgium

Belgium

Belgium

Belgium

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|-------------------------------|--|---|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 16680 | | | | | 16674 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | | c. LENGTH OF STAY IN TB
<u>10 ds.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore 21214</u> <u>30-4</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Summit Nursing Home</u> | | | | | d. STREET ADDRESS
<u>3108 Northern Parkway</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Mrs. Julia A Smith</u> | | | | | 4. DATE OF DEATH
Month <u>12</u> Day <u>18</u> Year <u>1967</u> | | | | |
| 5. SEX
<u>F</u> | | 6. COLOR OR RACE
<u>W.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Feb 25, 1890</u> | | 9. AGE (In years last birthday)
<u>77</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>John Henry Kexer</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Clara Puckett</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>212 28 8473A</u> | | 17. INFORMANT
<u>Mrs. Robert Romne (Daughter)</u> Address <u>222 Wickham Ave.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>1) Arteriosclerosis for cardiac resercher</u>
DUE TO <u>disease.</u>
(b) <u>2) Cerebrovascular accident.</u>
DUE TO <u>3) Coronary heart failure</u>
(c) <u>4) Diabetes Mellitus</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/18</u> , 19 <u>67</u> , to <u>12/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/18</u> , 19 <u>67</u> , and that death occurred at <u>3:45 p.m.</u> from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Edmund Kasaitis, M.D.</u> | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>12/18/67</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>EDMUND KASAITIS, M.D.</u> | | | | | 22d. ADDRESS
<u>1801 FREDRICK ROAD # 28</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 23b. DATE THEREOF
<u>12/21/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gardens of Faith</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore Co., Md.</u> | | |
| 24. FUNERAL DIRECTOR
<u>James E. Bruzdinski</u> ADDRESS
<u>1407 Eastern Ave. 21</u> | | | | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 26 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

University of Chicago

John Jones

Р

Frank

7

100-1000

John Henry Kerner

Charles Prescott

1892

• 54 •

FOR STATE
HEALTH DEPT.

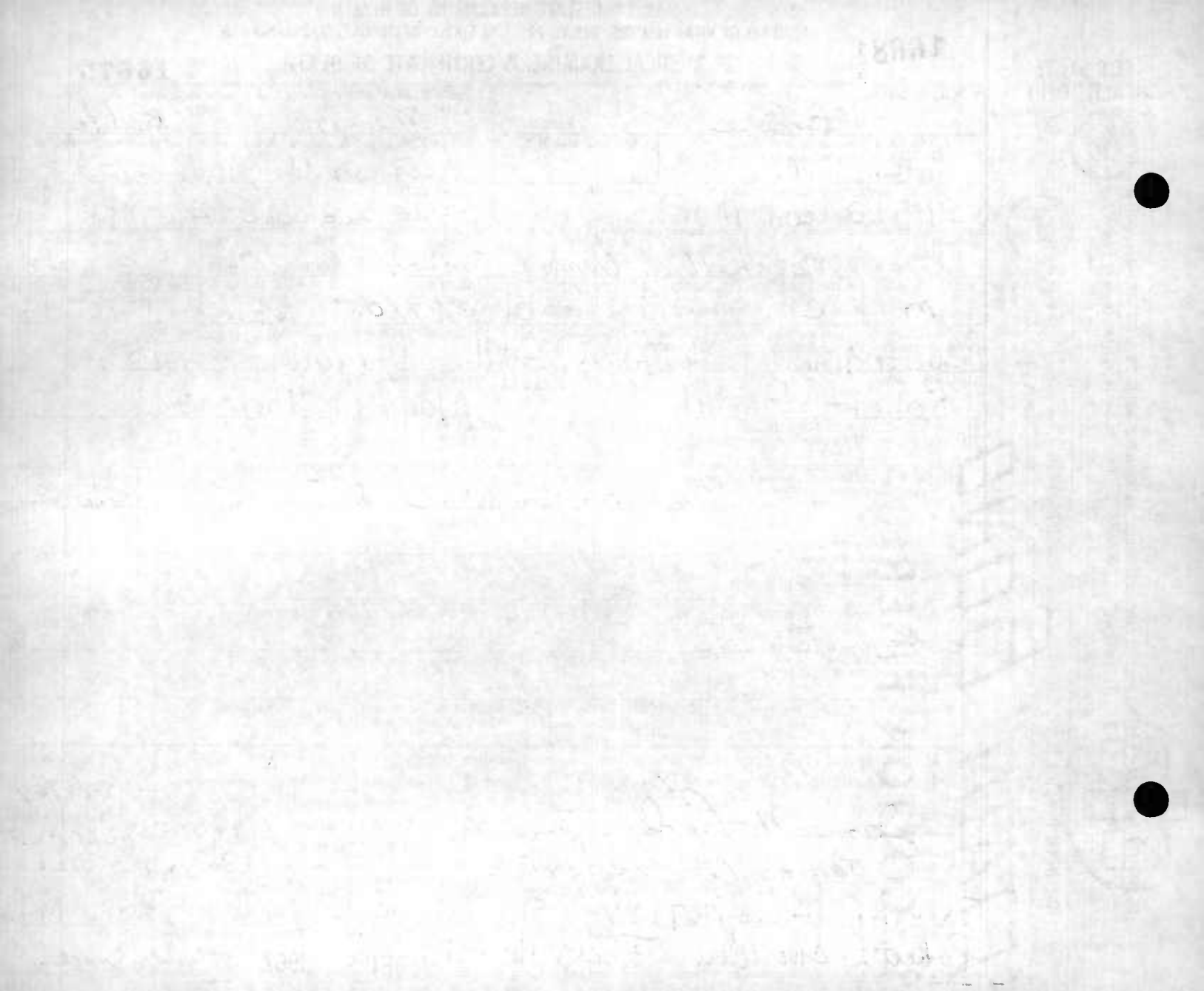
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 15 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville, Md. 21228</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>5913 Leewood Ave.</u> | | d. STREET ADDRESS
<u>5913 Leewood Ave.</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Marshall (NMN) Smith</u> | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>3</u> Year <u>1967</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8/17/05</u> |
| 9. AGE (In years last birthday)
<u>62</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Custodian</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Howard Co. School Board</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S. A.</u> | |
| 13. FATHER'S NAME
<u>Robert Smith</u> | | 14. MOTHER'S MAIDEN NAME
<u>Magnolia Thomas</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio-vascular Disease</u>
DUE TO <u>443X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u>
(c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Hypertension</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> <u>12/4/67</u> | | | |
| ACTUAL SIGNATURE <u>James N. Frederick</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>James N. Frederick</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1311 Francis Ave</u>
Address (Street, city, town, or county) <u>Balto Md 21227</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
| <u>BURIAL</u> | <u>Dec. 6 1967</u> | <u>West Star Cemetery</u> | <u>Catonsville, Balt. Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Robert L. Snowden</u> | | 25a. REC'D BY REGISTRAR
<u>Rockville, Md.</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DEC 8 1967 | |



16682

CERTIFICATE OF DEATH

16676

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Parkville | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Parkville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
7916 Oak Dale Avenue | | d. STREET ADDRESS
7916 Oakdale Ave. | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) First MARY Middle E. Last SMITH | | 4. DATE OF DEATH Month December Day 5 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-2-90 |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country)
Balto., Md. |
| 13. FATHER'S NAME
Jacob Buettner | | 14. MOTHER'S MAIDEN NAME
Maedelene Fink | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-03-2842D | |
| 17. INFORMANT
Madeline Andrew | | Address
7916 Oakdale Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Arteriosclerotic C-V Disease DUE TO
(c) Diabetes Mellitus | | | INTERVAL BETWEEN ONSET AND DEATH
5 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes Mellitus | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Apr 2 , 19 60 , to Dec 5 , 19 67 , that (I) (we) last saw the deceased alive on Dec 4 , 19 67 , and that death occurred at 8 A M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
George Sawyer | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED
12/5/67 |
| 22c. PHYSICIAN'S NAME (Type)
GEORGE SAWYER | | 22d. ADDRESS
4808 HARFORD RD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12-9-67 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | 23d. LOCATION (City or Town) (County) (State)
Balto., Md. |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR
DATE DEC 6 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16683

CERTIFICATE OF DEATH

16677

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
03-1 | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. JOSEPH HOSPITAL | | | | d. STREET ADDRESS
935 Woodlyn Rd. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Tonia Rene SMITH | | 4. DATE OF DEATH
Month December Day 5 Year 1967 | | 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. BIRTH DATE
November 14, 1967 | | 9. AGE (In years last birthday) yrs.
21 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
-- | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Arthur Lee Smith | | 14. MOTHER'S MAIDEN NAME
Arlene Shanaberger | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
Arthur L. Smith | | Address
Same | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemoperitoneum
DUE TO (b) laceration of spleen.
DUE TO (c) last. | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/14/ , 19 67 , to 12/5/ , 19 67 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 12/5/ , 19 67 , and that death occurred at 1:30 M, from causes on and on the date stated above. | |
| 22a. SIGNATURE
Samuel J. Misank | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
12/5/67 | | 22c. PHYSICIAN'S NAME (Type)
Lawrence F. Misank, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/7/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | 24. FUNERAL DIRECTOR
James E. Bruzdinski | |
| 25a. REC'D BY REGISTRAR
DEC 8 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 25c. ADDRESS
1407 Eastern Ave. | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson
c. LENGTH OF STAY IN 1b
Maryland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. JOSEPH HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21207
d. STREET ADDRESS
5200 Gwynndale Ave.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Florence L. SNYDER | | 4. DATE OF DEATH
Month Day Year
December 22, 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 3, 1897 |
| 9. AGE (In years last birthday)
70 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
George S. Lang | | 14. MOTHER'S MAIDEN NAME
Clara A. Lamney | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-05-9359 | |
| 17. INFORMANT
Mr. Arthur P. Munderloh, 1526 Fernley Rd. | | Address
21218 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho-pneumonia
DUE TO (b) Hepatic metastasis from carcinoma of colon
DUE TO (c) Coronary artery disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Coronary artery disease | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/20/ , 19 67 , to 12/22/ , 19 67 that (I) (we) last saw the deceased alive on 12/22/ , 19 67 , and that death occurred at 7 A. M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Keith A. Manley | | 22b. DATE SIGNED
12/22/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Keith A. Manley, M.D. | | 22d. ADDRESS
7503 Club Rd., Baltimore, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/26/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Meadowride Memorial Pk. | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | 25a. REC'D BY REGISTRAR
DEC 27 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--------------------------------------|--|---|--|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | | | 30-4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>TORRENT HAVEN NURS. HOME</u> | | | | | | d. STREET ADDRESS
<u>120 N Potomac ST</u> | | | | | |
| 3. NAME OF DECEASED (Type or print)
<u>Adam Sobotka</u> | | | | | | 4. DATE OF DEATH
Month <u>12</u> Day <u>11</u> Year <u>1967</u> | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>12-24-87</u> | | 9. AGE (In years last birthday) yrs. <u>79</u> | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>LONG SHOREMAN</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (Country & State, or foreign country)
<u>Poland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME
<u>FRANK SOBOTKA</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>TEOFIL ZWOTKOWSKA</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | | | 16. SOCIAL SECURITY NO.
<u>215-09-3327</u> | | 17. INFORMANT
<u>MARY HATHAWAY 120 N. POTOMAC ST</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PNEUMONIA + PULMONARY EMBOLISM</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>PERICARDIAL EFFUSION - UNDEVELOPED</u>
DUE TO
(c) <u>MI</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19
p.m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/23</u> , 19 <u>67</u> to <u>12/11</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12/11</u> , 19 <u>67</u> , and that death occurred at <u>11:00</u> M, from causes on and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>[Signature]</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>12/11/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>John M. Weber</u> | | | | | | 22d. ADDRESS
<u>5800 E. HANOVER ST. BALTO. MD.</u> | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>12-14-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>OAKLAWN CEM.</u> | | | | 23d. LOCATION (City or town) (County) (State)
<u>Balto. Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>JOHN M. WEBER & SONS INC 401 S. CHESTER ST.</u> | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 12 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON
c. LENGTH OF STAY IN TB 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. JOSEPH HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE
d. STREET ADDRESS 4910 ROSS RD. #21214
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) AGNES
First Middle Last
AGNES M. SOLOMON | | 4. DATE OF DEATH DECEMBER 19 1967
Month Day Year | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1889 AGE (In years last birthday) 78 yrs.
SEPTEMBER 28, 1889 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND |
| 13. FATHER'S NAME William Crout | | 14. MOTHER'S MAIDEN NAME Agnes ETtinger | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Stanley L Solomon Address Same |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro vascular accident (thrombosis)
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) cerebro arteriosclerosis
DUE TO
(c) diabetes mellitus | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 9, 1967 , to DECEMBER 19 1967 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 19 1967 , and that death occurred at 6:00AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE Lawrence F. Misanik, M.D. | | 22b. DATE SIGNED 12/19/67 | |
| 22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D. | | 22d. ADDRESS 7620 York Rd., Towson, Md., 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 12-22-1967 | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery | 23d. LOCATION (City or Town) (County) (State) Glen Burnie Md |
| 24. FUNERAL DIRECTOR Chas. T. Evanson ADDRESS 8802 Hartford Rd | | 25a. REC'D BY REGISTRAR DATE DEC 22 1967 | 25b. REGISTRAR'S SIGNATURE William Judge |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mount Wilson
c. LENGTH OF STAY IN b.
11 mo. 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Mount Wilson State Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
700 Park Ave
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
John E. SPRIGG | | 4. DATE OF DEATH
Month 12 Day 18 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9.25.1908 |
| 9. AGE (In years Months Days)
58 yrs. | | 10. IF UNDER 1 Year
Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bus driver | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
JOHN SPRIGG | | 14. MOTHER'S MAIDEN NAME
MODORA MOXLEY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
217-07-4005 | |
| 17. INFORMANT
Records, Mt. Wilson State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Follicular lymphoma of mesenterium | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 0 a.m. 19 p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1.17. , 19 67 , to 12.18 , 19 67 , that (I) (we) last saw the deceased alive on 12.18 19 67 , and that death occurred at 2:40 AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Wm. Newcomer | | 22b. DATE SIGNED
12.18.67. | |
| 22c. PHYSICIAN'S NAME (Type)
Wm. Newcomer, M.D., Superintendent | | 22d. ADDRESS
Mount Wilson, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12/21/67. | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR
DATE DEC 20 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | |

MEDICAL CERTIFICATION

1862

541 Clinton

Mount Wilson

Mount Wilson State Hospital

1862-1863

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W

Station

1862-1863

JOHN G. WILSON

JOSEPH A. WILSON

1862-1863, Mount Wilson State Hospital

Station, Mt.

Station, Mt. Wilson

1862-1863

Station, Mt. Wilson, 1862-1863

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

MEDICAL CERTIFICATION

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | c. LENGTH OF STAY IN 17 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
7421 School Avenue | | d. STREET ADDRESS
7421 School Avenue | |
| 3. NAME OF DECEASED (Type or print)
George Keister Steele | | 4. DATE OF DEATH
Month December Day 8 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 5, 1904 |
| 9. AGE (In years last birthday)
63 yrs. | | IF UNDER 1 YEAR
Months 03 Days 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Guard | | 10b. KIND OF BUSINESS OR INDUSTRY
Paul Jones Co. | |
| 11. BIRTHPLACE (State or foreign country)
Penna. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Steele | | 14. MOTHER'S MAIDEN NAME
Eleanor Keister | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
716-07-4962 | |
| 17. INFORMANT
(Wife) Ethel M. Steele | | Address Dundalk, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of Colon
DUE TO (b) Cervical Metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) — | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Knee | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
Knee | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
M B Davis | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Melvin B. Davis, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED
12/9/67 | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6800 Mornington Rd | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Dec 11, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
John J. Duda, 7922 Wise Ave. Dundalk, Md. | | 25a. REC'D BY REGISTRAR
DEC 12 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16689

CERTIFICATE OF DEATH

16683

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson
c. LENGTH OF STAY IN 1b
21204
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. JOSEPH HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
BALTO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
326 Dixie Dr.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Anne R STIELPER | | 4. DATE OF DEATH
Month Day Year
December 27, 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 2, 1908
9. AGE (In years lost birthday) yrs.
59 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Robert W Eigner | | 14. MOTHER'S MAIDEN NAME
Loretta R North | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mr Andrew H Stielper | | Address
Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive gastro-intestinal bleeding
DUE TO (b) advanced liver cirrhosis
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | 20g. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/29/ , 19 67 , to 12/27/ , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/27/ , 19 67 , and that death occurred at 9:50M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
William | | 22b. DATE SIGNED
12/27/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Ines Cilliani, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/30/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mt Maria | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md 21204 | |
| 24. FUNERAL DIRECTOR
Leonard J Ruck Inc. 5305 Harford Rd | | 25a. REC'D BY REGISTRAR
DATE DEC 28 1967 | |
| 25b. REGISTRAR'S SIGNATURE
William Judge | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

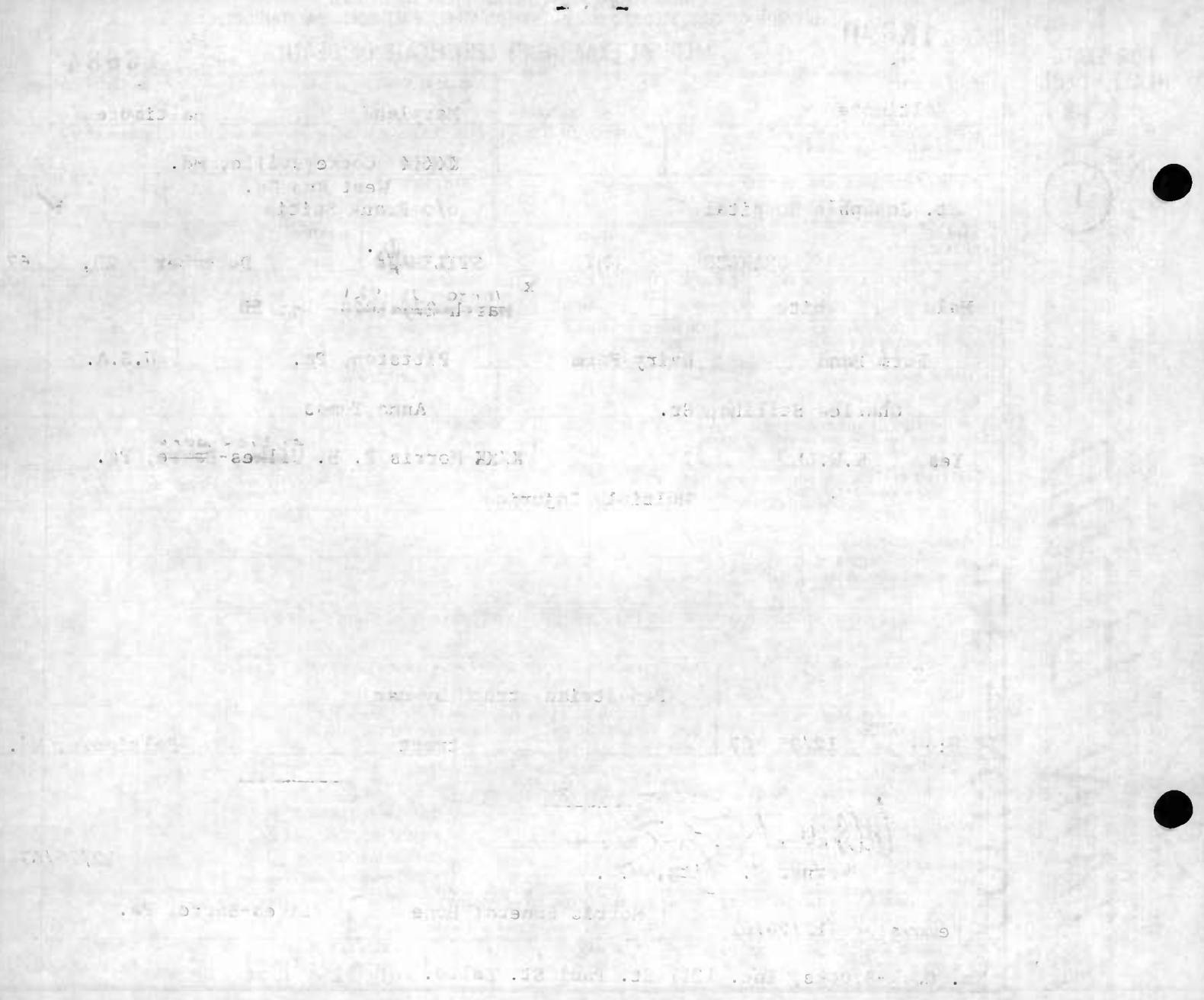
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16690

16684

| | | | |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph's Hospital | | d. STREET ADDRESS West Run Rd. c/o Frank Saitis | |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle NMI Last STILHA Jr. | | 4. DATE OF DEATH
Month December Day 25 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MARCH 21, 1921
March 27, 1920 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farm Hand | | 10b. KIND OF BUSINESS OR INDUSTRY
Dairy Farm | |
| 11. BIRTHPLACE (State or foreign country)
Pittston, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles Stiliha, Sr. | | 14. MOTHER'S MAIDEN NAME
Anna Tomas | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes W.W.II | | 16. SOCIAL SECURITY NO.
? | |
| 17. INFORMANT
XXXX Morris F. H. Wilkes-Barre, Pa. | | Address
EXETER BORO | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
8124 Multiple Injuries
IMMEDIATE CAUSE (a) DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Pedestrian struck by car | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 8:30 p.m. 12/25 19 67 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
street | | 20f. (City or town) (County) (State)
Baltimore, Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) | |
| 22. DATE SIGNED
12/26/67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | 23b. DATE THEREOF
12/26/67 | 23c. NAME OF CEMETERY OR CREMATORY
Morris Funeral Home | 23d. LOCATION (City or town) (County) (State)
Wilkes-Barre, Pa. |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks, Inc. 1217 St. Paul St. Balto. | | 25a. REC'D BY REGISTRAR
DEC 28 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16691

CERTIFICATE OF DEATH

16685

| | | | |
|--|--------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Perry Hall (twnl)</u> | | c. LENGTH OF STAY IN 1b
<u>Perry Hall, Md. 21128</u> 03-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Box 208 Cross Road</u> | | d. STREET ADDRESS
<u>Box 208 Cross Road</u> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Anna C. Stocker</u> | | 4. DATE OF DEATH
Month Day Year
<u>12 26 19 67</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Cau</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>6-2-7-1893</u> |
| 9. AGE (In years last birthday)
<u>74</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
<u>12 26 19 67</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Housewife</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Balto. Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>George Hoffmann</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>212-22-5578</u> | |
| 17. INFORMANT
<u>Mrs Pauline Drumgoole Cross Rd. Perry Hall</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO
(b) <u>Arteriosclerotic Cardio Vascular Disease</u>
DUE TO
(c) <u>Sudden</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>2 yrs</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1</u> , 19 <u>67</u> , to <u>Dec 25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 25</u> , 19 <u>67</u> , and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>M. Brumbyard</u> M.D. | | 22b. DATE SIGNED
<u>12/27/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>12-27-1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Scarsdale H 7401 Belair Rd.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 2 1968</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>James Judge</u> | | | |

1922

REPORT OF THE

1922

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "REPORT", "BUREAU", and "DEPARTMENT" are faintly visible.]

CERTIFICATE OF DEATH

16692

16686

| | | | | | | | |
|---|----------------------------------|---|-------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>RURAL</u> | | c. LENGTH OF STAY IN 1b
<u>3 YEARS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>VILLA MARIA - NOTCH CLIFF</u> | | | | d. STREET ADDRESS
<u>Glen Arm</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Sister Mary EUSTACE STRASSNER</u> | | | | 4. DATE OF DEATH
Month <u>12</u> Day <u>2</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2-4-1893</u> | 9. AGE (In years lost birthday) yrs.
<u>74</u> | IF UNDER 1 YEAR
Months _____ Days _____ | | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Teacher-Voice Mistress</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>CONVENT</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Rochester-New York</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>George</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Lawrence</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>220-54-6380-11</u> | | 17. INFORMANT
<u>S. Catherine Mary-Viola Maria Hotel Cliff</u> | | Address <u>Blondine P.O. Md. 21037</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Complications thereof</u>
DUE TO
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>DEC. 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 1</u> , 19 <u>67</u> , and that death occurred at <u>6:40 A.M.</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Henry L. McCorke</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>HENRY L. MCCORKE MD</u> | | | | 22d. ADDRESS
<u>Phoenix, Maryland 21131</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>DEC. 5, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>SISTERS CEMETERY</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>GLEN ARM, BALTIMORE, MD.</u> | |
| 24. FUNERAL DIRECTOR
<u>RAYMOND J. CURRAN</u> | | | | ADDRESS
<u>817 SCRIBNER DR. TOWSON, MD. 21204</u> | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 8</u> 19 <u>67</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10025

RECORD OF DEATH

1887

DEATH OF THE LATE MR. ROBERT B. DUNN, JR. OF
NEW YORK, N. Y. IN THE CITY OF NEW YORK,
COUNTY OF NEW YORK, ON THE 10TH DAY OF
JANUARY, 1887, AT THE AGE OF 35 YEARS,
AND THE DEATH OF THE LATE MRS. ELIZABETH
DUNN, IN THE CITY OF NEW YORK, COUNTY OF
NEW YORK, ON THE 10TH DAY OF JANUARY,
1887, AT THE AGE OF 65 YEARS.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16693
16687
CERTIFICATE OF DEATH

| | | | |
|--|--------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural - Towson
c. LENGTH OF STAY IN 1b
49 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Greater Baltimore Medical Center | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
304 Baltimore
d. STREET ADDRESS
2805 Louise Ave
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Robert Cook Sturgeon | | 4. DATE OF DEATH
Month Day Year
12 28 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cau | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/15/97 |
| 9. AGE (In years last birthday)
70 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
0 0 0 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Brick Layer | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | |
| 11. BIRTHPLACE (County & State, or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Sturgeon | | 14. MOTHER'S MAIDEN NAME
Emma Douglas | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW 1 | | 16. SOCIAL SECURITY NO.
215-03-1080 | |
| 17. INFORMANT
Mrs Alma L Sturgeon | | Address
Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of pancreas with wide spread metastases
157X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/9/1967 , to 12/28/1967 , that (I) (we) last saw the deceased alive on 12/27/1967 , and that death occurred at 5 a.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
R. Breiteneker
22b. DATE SIGNED
12/28/67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
R. Breiteneker, M.D.
22d. ADDRESS
6701 N. Charles Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial
23b. DATE THEREOF
12/1/2/68
23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith
23d. LOCATION (City, town or county) (State)
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
Leonard J Ruck Inc 5305 Harford Rd
25a. REC'D BY REGISTRAR
JAN 2 1968
25b. REGISTRAR'S SIGNATURE
Charles Jones | | | |

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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|---|--|--|--|--|--|--|---|---|--|---|--|--|
| 16695 | | | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 16689 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | c. LENGTH OF STAY IN lb
10 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
XXXXXX Baltimore Highlands 037 | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS
2905 Louisiana Avenue | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Charles Ray Sullivan | | | | 4. DATE OF DEATH
Month Day Year
December 12 19 67 | | | | | | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Feb. 23, 1908 | | 9. AGE (In years birthday) yrs.
59 | | IF UNDER 1 YEAR
Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
handy man | | | 10b. KIND OF BUSINESS OR INDUSTRY
American Ice Co. | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | |
| 13. FATHER'S NAME
XXXXXXXXXX Raymond R. Sullivan | | | | 14. MOTHER'S MAIDEN NAME
Ida Mendell | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO.
214-01-5080 | | 17. INFORMANT
Address
Records: SPRING GROVE STATE HOSPITAL | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolism, suspected,
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Varicose Veins, Moderate, Bilateral
DUE TO
(c)
10 years. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 hr. | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Alcoholism, Chronic; Delirium Tremens, early; ASCVH Disease | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | |
| 21. I certify that (X) (this hospital) attended the deceased from Dec. 2 , 19 67 , to Dec. 12 , 19 67 , that (X) (we) last saw the deceased alive on Dec. 12 , 19 67 , and that death occurred at 3:15 M, from causes and on the date stated above. | | | | | | | | | | | | |
| 22a. SIGNATURE
<i>Anthony J. Young</i> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
M.D. Anthony J. Young, M.D. | | | | 22b. DATE SIGNED
12-13-67 | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12-16-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Howard H. Hubbard, 4107 Wilkens Avenue 21229 | | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 15 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>John Charles Jones</i> | | | | |

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CONTRACT OF SALE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16696

CERTIFICATE OF DEATH

16696

| | | | | | |
|--|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
10 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | d. STREET ADDRESS
319 PARK AVENUE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle LEWIS Last SULLIVAN | | | 4. DATE OF DEATH
Month DECEMBER Day 8 Year 19 67 | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/23/91 | | 9. AGE (In years last birthday) yrs. 76 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MANAGER | | 10b. KIND OF BUSINESS OR INDUSTRY
RACE TRACK | 11. BIRTHPLACE (County & State, or foreign country)
MARTINSBURG, WEST VA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
PATRICK L SULLIVAN | | | 14. MOTHER'S MAIDEN NAME
CATHERINE B MAHONEY | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | 16. SOCIAL SECURITY NO.
265 07 90 95 | 17. INFORMANT Address MARYLAND
CLIN.RECORDS, VA HOSPITAL, FORT HOWARD, | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, undet. organism
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Metastases to Lt. kidney, Lt. Adrenal gland
DUE TO
(c) Tumor of lung, RLL, unspecified type | | | | | INTERVAL BETWEEN ONSET AND DEATH
?
? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Remote myocardial infarction; Interstitial pulmonary fibrosis | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/28/67 , 19__, to 12/8/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/8/67 , 19__, and that death occurred at 4:00 PM , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<i>Neilon Neilson</i> | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED
12/8/67 | | |
| 22c. PHYSICIAN'S NAME (Type)
NEILON NEILSON, M.D. | | 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
12-12-67 | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
EVANS FUNERAL HOME, 8802 HARFORD RD, BALTO | | 25a. REC'D BY REGISTRAR
DEC 12 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

540174

DRAWING TOOL

10 DAYS

BAPTISTE

RECEIVED: 1964 FEB 11 10 11 AM

THE WORKS OF

TABLE 1

C. J. W. S.

WAVELENGTH

NAME _____ DATE _____

2

19/05/15

RACE TRACK

WABD 12345, 6789012345

PATRICK J. SULLIVAN

CATHY LEE B. MANDREY

288

528

365 07 90 95 CLIN. RECORDS, VA HOSPITAL, FORT HOWARD,

Epidemiology, 1987, 98, 60-61

For contact to Lt. Kinney, Lt. Abner, or

Index of fund, R.R., unspecified type

Remote myocardial infarction; Interstitial pulmonary fibrosis

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15/8/07

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EILON WILSON, M.D.

VA HOSPITAL, FORT HOWARD, MARYLAND

WHAT?

BALTIMORE NATIONAL

BALTIMORE, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Balto. Co.
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Boring
c. LENGTH OF STAY IN 1b
Boring
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 48 | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md.
b. COUNTY Balto. Co.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Boring
d. STREET ADDRESS Box 48
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Albert Middle P. Last SWEISFORD | | 4. DATE OF DEATH
Month Dec. Day 21 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 29, 1894 |
| 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur | | 10b. KIND OF BUSINESS OR INDUSTRY Trucking | |
| 11. BIRTHPLACE (County & State, or foreign country) Danville Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Sweisford | | 14. MOTHER'S MAIDEN NAME Elizabeth Eckert | |
| 15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 220-14-3521A | |
| 17. INFORMANT Mrs. Thelma Sweisford | | Address Boring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure
DUE TO (b) Pyo-nephrosis
DUE TO (c) Benign Hypertrophy of Prostate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH
6-7 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April , 19 65 , to Dec. 21 , 19 67 , that (II) (we) last saw the deceased alive on Dec. 20 , 19 67 , and that death occurred at 11:30 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE M.C. Porterfield | | 22b. DATE SIGNED 12-21-67 | |
| 22c. PHYSICIAN'S NAME (Type) M.C. Porterfield | | 22d. ADDRESS HAMPSTEAD, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 23, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery | | 23d. LOCATION (City, town or county) (State) Danville Pa. | |
| 24. FUNERAL DIRECTOR Tipton - Eline Funeral Home | | 25a. REC'D BY REGISTRAR DEC 29 1967 | |
| ADDRESS Hampstead, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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1881

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Pat. Co.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
|---|----------------------------------|---|--------------------------------------|
| CERTIFICATE OF DEATH | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md.
b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN lb
Towson | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
609 Coventry Rd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Georgina First L Middle Tabeling Last | | 4. DATE OF DEATH
Month 12 Day 19 Year 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/26/1899 |
| 9. AGE (In years last birthday) yrs.
68 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
George Schuchhardt | | 14. MOTHER'S MAIDEN NAME
Katherine Helldorfer | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
215-58-4830 | |
| 17. INFORMANT
William J. Tabeling | | Address
609 Coventry Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
3560 IMMEDIATE CAUSE (a) PROGRESSIVE BULBAR PALSY
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 11, 1967 , to Dec. 19, 1967 , that (I) (we) last saw the deceased alive on Dec. 18, 1967 , and that death occurred at 3 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
S.J. Venable Jr. | | 22b. DATE SIGNED
12-20-67 | |
| 22c. PHYSICIAN'S NAME (Type)
S.J. Venable Jr. | | 22d. ADDRESS
7215 York Rd. Baltimore, MD | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/21/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetry | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
Mitchell Wiedefeld Home | | 25a. REC'D BY REGISTRAR
DATE DEC 29 1967 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

1962

Baltimore

Towson

609 Coventry Rd.

Georgia

Female White

Homemaker

George Schnobelsky

Marlene Schnobelsky

609 Coventry Rd. Baltimore, Md.

E. J. Venable Jr.

1215 York Rd.

Baltimore, Md.

Michael W. Gifford Home 650 York Rd.

CERTIFICATE OF DEATH

16693

16693

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Reisterstown</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Reisterstown</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Chapel Hill Nursing Home</i> | | d. STREET ADDRESS
<i>311 Main Street</i> | |
| 3. NAME OF DECEASED (Type or print)
<i>Eunice</i> First <i>E.</i> Middle <i>Talbert</i> Last | | 4. DATE OF DEATH
Month <i>December</i> Day <i>2</i> Year <i>67</i> | |
| 5. SEX
<i>Female</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>Aug. 31, 1902</i> |
| 9. AGE (In years last birthday) yrs.
<i>65</i> | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<i>Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME
<i>Lydia Southard</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<i>Mr. Henry J. Talbert</i> | | Address
<i>Reisterstown, Md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinoma of stomach</i>
DUE TO <i>Cooling</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO <i>Cachexia</i>
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 yr</i>
<i>4 yrs</i>
<i>6 mos</i> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <i>19</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1-1-67</i> , 19 <i>67</i> to <i>12-2-67</i> , that (I) (we) last saw the deceased alive on <i>12-1-67</i> , and that death occurred at <i>1:30</i> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>James G. Saffell</i> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<i>James G. Saffell</i> | | 22d. ADDRESS
<i>Reisterstown Md</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | 23b. DATE THEREOF
<i>Dec. 5, 67</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Evergreen Memorial</i> | 23d. LOCATION (City or Town) (County) (State)
<i>Finksburg, Md.</i> |
| 24. FUNERAL DIRECTOR
<i>J. F. Eline & Sons</i> | | 25a. REC'D BY REGISTRAR
DATE <i>DEC 4 1967</i> | |
| ADDRESS
<i>Reisterstown, Md.</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1951

RECEIVED

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1951

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CERTIFICATE OF DEATH

16694

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson
c. LENGTH OF STAY IN 1b
30-4 | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore 21234 | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Edna TATE | | 4. DATE OF DEATH
Month Day Year
December 26, 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 17 1913 |
| 9. AGE (In years last birthday)
54 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Robt S. TATE | | 14. MOTHER'S MAIDEN NAME
Agnes M. Gaubatz | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
213-16-5413 | |
| 17. INFORMANT
Brother | | Address
Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive aspiration of blood of both lung
DUE TO (b) rupture of varicose esophageal veins secondary to portal liver cirrhosis.
DUE TO (c) to portal liver cirrhosis. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour o.m. Month, Day, Year
p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/22/ , 19 67 to 12/26/ , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/26/ , 19 67 , and that death occurred at 8:30AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
William | | 22b. DATE SIGNED
12/26/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Ines Cilliani, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
12/30/67 | 23c. NAME OF CEMETERY OR CREMATORY
Fondren Ch. | 23d. LOCATION (City or Town) (County) (State)
Baltimore |
| 24. FUNERAL DIRECTOR
W. Steenmann 6667 Bay Rd | | 25a. REC'D BY REGISTRAR
DATE JAN 2 1968 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16701

16695

| | | | | | | | |
|--|----------------------------------|---|-------------------------------------|--|--|---|---|
| 1. PLACE OF DEATH
o. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE MARYLAND b. COUNTY — | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN lb
1 1/2 HOURS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE 21217 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
2015 MC CULLOH STREET | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
TAYLOR -- TAZEWEILL | | | | 4. DATE OF DEATH
Month Day Year
DECEMBER 7 1967 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
4/7/1897 | | 9. AGE (In years birthday) yrs.
70 | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY
FARM | | 11. BIRTHPLACE (County & State, or foreign country)
GLOUCESTER, VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
WILLIAM TAZEWEILL | | | | 14. MOTHER'S MAIDEN NAME
MARY ELLEN ROWE | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DIABETIC ACIDOSIS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b)
DUE TO
(c)
260X | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from 12/7/67 , 19__ to 12/7/67 , 19__, that (I) (we) last saw the deceased alive on 12/7/67 , 19__, and that death occurred at 8:30AM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>John D. Talbert</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
12/8/67 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M. D. | | | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Dec 12, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
SHILOH BAPTIST CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
GLOUCESTER CO. VA. | |
| 24. FUNERAL DIRECTOR
Herbert E. Nutter
3035 W. North Ave. | | ADDRESS
NUTTER FUNERAL HOME
BALTIMORE, MARYLAND | | 25a. REC'D BY REGISTRAR
DATE DEC 12 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. J...</i> | |

STATEMENT OF CLAIM

18701

DATE

AMOUNT

REMARKS

NO. OF INVOICE

DATE OF INVOICE

NAME OF DEBITOR

NAME OF CREDITOR

DATE

AMOUNT

REMARKS

AMOUNT

DATE

NAME OF DEBITOR

NO. OF INVOICE

DATE OF INVOICE

REMARKS

AMOUNT

NAME OF DEBITOR

NO. OF INVOICE

DATE OF INVOICE

REMARKS

DATE

AMOUNT

REMARKS

NAME OF DEBITOR

NO. OF INVOICE

NAME OF DEBITOR

NO. OF INVOICE

NAME OF DEBITOR

NO. OF INVOICE

DATE OF INVOICE

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16702

CERTIFICATE OF DEATH

16696

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|---|------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | | c. LENGTH OF STAY IN 1b
2yrlmthl7dys | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Spring Grove State Hospital | | | | d. STREET ADDRESS
608 Meadow Road | | | |
| 3. NAME OF DECEASED (Type or print)
First Eloncie Middle ALEIN Last Teubner | | | | 4. DATE OF DEATH
Month December Day 7 Year 19 67 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-16-04 | | 9. AGE (In years last birthday)
63 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Otto Wingate | | | | 14. MOTHER'S MAIDEN NAME
Margaret | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
212-03-1243
unknown | | 17. INFORMANT
Records: Spring Grove State Hospital | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1913 Carcinoma of the face, histopathology
DUE TO undetermined, with extensive invasion in
(b) to the skull and to the brain
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
23 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (this hospital) attended the deceased from 10-20-65 , 19 to Dec. 7 19 67 , that (we) last saw the deceased alive on Dec. 7 1967 , and that death occurred at 8:00 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Anthony J. Young</i> | | | | 22b. DATE SIGNED
12-8-67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | | | 22d. ADDRESS
Spring Grove State Hospital
Baltimore, Maryland 21228 | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) | 23b. DATE THEREOF
12/11/67 | 23c. NAME OF CEMETERY OR CREMATORY
Louisa Park | | 23d. LOCATION (City or Town) (County) (State)
Balto Md | | | |
| 24. FUNERAL DIRECTOR
Henry Sander & Sons Inc. Balto Md | | | | 25a. REC'D BY REGISTRAR
DEC 12 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

ALLEN

2000

10-37-5
GroupB

315-03-1543

Vol 17

Ant. Schubert 12/11/21

Thrupp & Co. Boston

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 16703 | | | | | 16697 | | | | |
| 1 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | c. LENGTH OF STAY IN lb
1yr8mth22dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | | d. STREET ADDRESS
4225 Potter Street | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
Mae Agnes Theborge | | | First Middle Last | | 4. DATE OF DEATH
Month Day Year
December 14 19 67 | | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 1, 1888 | | 9. AGE (In years last birthday)
79 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Scotland | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | |
| 13. FATHER'S NAME
James Higgins | | | | | 14. MOTHER'S MAIDEN NAME
Mary Marley | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO.
223-03-9701D | | 17. INFORMANT
Address
Records: SPRING GROVE STATE HOSPITAL | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
493X IMMEDIATE CAUSE (a) Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that the (this hospital) attended the deceased from March 22, 19 66 to Dec. 14, 19 67 that it (we) last saw the deceased alive on Dec. 14, 19 67 , and that death occurred at 5:30 P.M. from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Michael W. Kilchenstein M.D. | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
12-14-67 | | |
| 22c. PHYSICIAN'S NAME (Type)
Michael W. Kilchenstein M. D. | | | | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12-19-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Avenue 21229 | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 18 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

12072-12073

3-63 (52) 3

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any page is necessary, please execute a separate certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

| MAYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--------------------------------------|--|---|--|---|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16698 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD. b. COUNTY BALTIMORE | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
DUNDALK | | | | c. LENGTH OF STAY IN 1b
10 YRS. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
DUNDALK 03-1 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1943 DUNDALK AVE | | | | | | d. STREET ADDRESS
1943 DUNDALK AVE. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
HENRY SYLVESTER THOMAS | | | | | | 4. DATE OF DEATH
Month Day Year
28 DEC. 1967 | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
CAUCASIAN | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH
2 AUG. 1913 | | 9. AGE (In years last birthday)
54 yrs. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FOREMAN | | | | 10b. KIND OF BUSINESS OR INDUSTRY
TEXTILE INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
N. CAROLINA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
JOSEPH S. THOMAS | | | | | | 14. MOTHER'S MAIDEN NAME
MARY JUSTICE | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | | | 16. SOCIAL SECURITY NO.
42-01-3244 | | | | | |
| 17. INFORMANT
PAUL S. THOMAS | | | | | | Address
1217 SOUTHBEND DR. ALVIN, TEXAS | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO A-S-C-V-DISEASE
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
M.B. Davis, M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type)
M.B. Davis, M.D. | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | Address (Street, city, town, or county)
6800 MORNINGTON DUNDALK, MD | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 22b. DATE THEREOF
1/1/1968 | | 22c. NAME OF CEMETERY OR CREMATORY
OAKWOOD | | | | 22d. LOCATION (City, town, or county) (State)
CONCORD, N.C. | |
| 23. FUNERAL DIRECTOR
W. Drake Dudley, Dundalk, Md. | | | | | | 24a. REC'D BY REGISTRAR
DATE JAN 2 1968 | | | | | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

MEDICAL CERTIFICATION

RECEIVED

1951

RECEIVED

1951

1951



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copy papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
|---|----------------------------------|---|--|--|---|---|---|
| 16705 | | | | 16699 | | | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
52 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE - 21223 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
954 W. SARATOGA STREET | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle HENRY Last TILGHMAN | | | | 4. DATE OF DEATH
Month DECEMBER Day 18 Year 19 67 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
JUNE 17, 1910 | | 9. AGE (In years last birthday) yrs.
57 | | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
STEVEDORE | | 10b. KIND OF BUSINESS OR INDUSTRY
SHIPPING | | 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CHARLES H. TILGHMAN | | | | 14. MOTHER'S MAIDEN NAME
IDA M. WILLIAMS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW II | | 16. SOCIAL SECURITY NO.
214 12 22 52 | | 17. INFORMANT
Address
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
443X IMMEDIATE CAUSE (a) BRAIN STEM HEMORRHAGE
DUE TO
(b) HYPERTENSIVE CARDIOVASCULAR DISEASE
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)
BRONCHOPNEUMONIA | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/27/67 , 19__ to 12/18/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/18/67 , 19__, and that death occurred at 7:30P M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
John D. Talbert | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
12/19/67 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M. D. | | | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12-22-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
Chroy O. Wilson | | | | ADDRESS
WILSON FUNERAL HOME
ORLEANS ST. BALTIMORE, MD. | | 25a. REC'D BY REGISTRAR
DATE DEC 20 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

1885

1885

RECORD OF DEATH

WILLIAM - 1885

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|--|--|---|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY _____ | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | c. LENGTH OF STAY IN 1b
10 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | | | | d. STREET ADDRESS
1732 Milton Avenue | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) FRANK First Middle Last TOLIVER | | | | | 4. DATE OF DEATH
Month December Day 28 Year 1967 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Dec. 25, 1916 | | 9. AGE (In years last birthday) yrs. 51
IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Crane Operator | | | 10b. KIND OF BUSINESS OR INDUSTRY
Shipyard | | 11. BIRTHPLACE (County & State, or foreign country)
Fairfield, S.C. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Robert Toliver | | | | | 14. MOTHER'S MAIDEN NAME
Adeline Brown | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes WW-11 | | 16. SOCIAL SECURITY NO.
249 16 91 71 | | 17. INFORMANT Address
Clinical Rcds, VA Hospital, Fort Howard, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UREMIA
DUE TO (b) —
DUE TO (c) ARTERIOLEAR NEPHROSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. _____ | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
ot work <input type="checkbox"/> ot work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 18, 1967 , to Dec. 28, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 28, 1967 , and that death occurred at 1 P.M. , from causes and on the date stated above | | | | | | | | | |
| 22a. SIGNATURE
<i>Neilson Neilson</i> | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
12/28/67 | | |
| 22c. PHYSICIAN'S NAME (Type)
NEILSON, NEILSON, M.D. | | | | | 22d. ADDRESS
VA Hospital, Fort Howard, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 23b. DATE WHEREOF
12-29-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Pilgrim Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Chester, South Carolina | | |
| 24. FUNERAL DIRECTOR
COLLICK FUNERAL HOME | | | | | 25a. REC'D BY REGISTRAR
2431 E Oliver St Balto, Md. | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. [Signature]</i> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16707
16701
CERTIFICATE OF DEATH

| | | | |
|--|--|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE <u>Pennsylvania</u> b. COUNTY <u>Allentown</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson - Baltimore</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Allentown</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u> | | d. STREET ADDRESS <u>1444 Hamilton street</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>William</u> Last <u>Traylor, Jr.</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1967</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-24-96</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u> | | 9b. KIND OF BUSINESS OR INDUSTRY | |
| 10a. BIRTHPLACE (County & State, or foreign country) <u>Denver, Colorado</u> | | 10b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 11. FATHER'S NAME <u>Samuel William Traylor, Sr.</u> | | 12. MOTHER'S MAIDEN NAME <u>Belle Binkley</u> | |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> | | 14. SOCIAL SECURITY NO. <u>194-07-9798</u> | |
| 15. INFORMANT | | Address | |
| 16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Renal shut down</u>
161X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>several cardiac arrests + myocardial infarct</u>
DUE TO
(c) <u>post op laryngectomy for cancer of larynx</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>2 weeks</u>
<u>2 weeks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/2</u> , 19 <u>67</u> , to <u>12/6</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>12/6</u> , 19 <u>67</u> , and that death occurred at <u>9 p.</u> M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>M. E. H. Cooney</u> | | 22b. DATE SIGNED <u>12/6/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12-9-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Grandview Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Allentown, Penna.</u> | |
| 24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson,</u> | | 25a. REC'D BY REGISTRAR <u>REC 11 1967</u> | |
| ADDRESS <u>1050 York Road Towson, Maryland 21204</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

16708

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16702

| | | | |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Balto</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Monkton</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>St. Joseph's Hospital</u> | | d. STREET ADDRESS
<u>Big Falls Rd.</u> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>ANNIE LAURA TURNER</u> | | 4. DATE OF DEATH
Month Day Year
<u>12 4 1967</u> | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>NEGROID</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9-15-08</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) yrs. <u>59</u> |
| 11. BIRTHPLACE (State or foreign country)
<u>VA.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME
<u>ALFREATHA JENKINS</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>220-24-8587</u> | |
| 17. INFORMANT
<u>ROBERT TURNER</u> | | Address
<u>SAME</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
4201
DUE TO
(b) <u>Hypertensive Cardio Renal</u>
DUE TO
(c) <u>Vascular Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u>
<u>5 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D. | | 22. DATE SIGNED
<u>12/4/67</u> | |
| EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>12/8/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Arbutus Mem. Pk.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Arbutus, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Kelson Funeral Home</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| ADDRESS
<u>1348 Calhoun St.</u> | | DATE
<u>DEC 5 1967</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 and 2

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16709

CERTIFICATE OF DEATH

16703

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21206
d. STREET ADDRESS
7 Fuller Ave.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Stella Middle B. Last TURNER | | 4. DATE OF DEATH
Month December Day 1 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
September 19, 1897
9. AGE (In years lost birthday) 70 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
Housewife | 11. BIRTHPLACE (County & State, or foreign country)
Maryland |
| 13. FATHER'S NAME
Unknown Buettner | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | 16. SOCIAL SECURITY NO.
218-14-0856A | 17. INFORMANT
Address
Mr James E. Turner 7 Fuller Avenue 21206 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma of the lung
DUE TO (b) Primary in the right breast
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. _____ 19 _____ | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/29/ 19 67 , to 12/1/ 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/1/ 19 67 and that death occurred at 2:52 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Inez Cilliani | | 22b. DATE SIGNED
12/2/1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Inez Cilliani, M. D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12-4-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co. Md. |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home 7401 Belair Rd | | 25a. REC'D BY REGISTRAR
DATE DEC 4 1967 | 25b. REGISTRAR'S SIGNATURE
J Charles Jones |

1970

MINISTRY OF DEFENSE

1970

1. The Ministry of Defense is pleased to announce that the following personnel have been promoted to the rank of Major General:

| Name | Rank | Effective Date |
|------------------|---------------|----------------|
| John A. Smith | Major General | 1970 |
| Robert L. Jones | Major General | 1970 |
| William H. Brown | Major General | 1970 |
| Charles E. Davis | Major General | 1970 |
| Thomas M. Wilson | Major General | 1970 |

2. The following personnel have been promoted to the rank of Colonel:

| Name | Rank | Effective Date |
|-------------------|---------|----------------|
| James K. Miller | Colonel | 1970 |
| Richard S. Moore | Colonel | 1970 |
| Donald R. Taylor | Colonel | 1970 |
| Edward J. White | Colonel | 1970 |
| Franklin D. Black | Colonel | 1970 |

3. The following personnel have been promoted to the rank of Lieutenant Colonel:

| Name | Rank | Effective Date |
|------------------|--------------------|----------------|
| Gregory L. Green | Lieutenant Colonel | 1970 |
| Harold W. Adams | Lieutenant Colonel | 1970 |
| Isaac B. Baker | Lieutenant Colonel | 1970 |
| Jerome C. Clark | Lieutenant Colonel | 1970 |
| Keith D. Evans | Lieutenant Colonel | 1970 |

4. The following personnel have been promoted to the rank of Major:

| Name | Rank | Effective Date |
|------------------|-------|----------------|
| Lester E. Fox | Major | 1970 |
| Marion F. Gibson | Major | 1970 |
| Nathan G. Hall | Major | 1970 |
| Oliver H. Hill | Major | 1970 |
| Philip I. Young | Major | 1970 |

5. The following personnel have been promoted to the rank of Captain:

| Name | Rank | Effective Date |
|---------------------|---------|----------------|
| Quinn J. King | Captain | 1970 |
| Ronald K. Lamb | Captain | 1970 |
| Samuel L. Lee | Captain | 1970 |
| Timothy M. Martin | Captain | 1970 |
| Ulysses N. Mitchell | Captain | 1970 |

6. The following personnel have been promoted to the rank of First Lieutenant:

| Name | Rank | Effective Date |
|--------------------|------------------|----------------|
| Vernon O. Nelson | First Lieutenant | 1970 |
| Walter P. Phillips | First Lieutenant | 1970 |
| Xavier Q. Quinn | First Lieutenant | 1970 |
| Yvonne R. Reed | First Lieutenant | 1970 |
| Zachary S. Smith | First Lieutenant | 1970 |

7. The following personnel have been promoted to the rank of Second Lieutenant:

| Name | Rank | Effective Date |
|--------------------|-------------------|----------------|
| Adam T. Taylor | Second Lieutenant | 1970 |
| Brian U. Underhill | Second Lieutenant | 1970 |
| Carl V. Vance | Second Lieutenant | 1970 |
| Daniel W. Walker | Second Lieutenant | 1970 |
| Edward X. White | Second Lieutenant | 1970 |

8. The following personnel have been promoted to the rank of Private First Class:

| Name | Rank | Effective Date |
|---------------------|---------------------|----------------|
| Fred Y. Young | Private First Class | 1970 |
| Gerald Z. Zimmerman | Private First Class | 1970 |
| Henry A. Adams | Private First Class | 1970 |
| Ivan B. Baker | Private First Class | 1970 |
| Jack C. Clark | Private First Class | 1970 |

9. The following personnel have been promoted to the rank of Private:

| Name | Rank | Effective Date |
|------------------|---------|----------------|
| Kenneth D. Davis | Private | 1970 |
| Larry E. Evans | Private | 1970 |
| Michael F. Fox | Private | 1970 |
| Nathan G. Gibson | Private | 1970 |
| Oliver H. Hall | Private | 1970 |

10. The following personnel have been promoted to the rank of Sergeant:

| Name | Rank | Effective Date |
|-------------------|----------|----------------|
| Paul I. Hill | Sergeant | 1970 |
| Quinn J. King | Sergeant | 1970 |
| Ronald K. Lamb | Sergeant | 1970 |
| Samuel L. Lee | Sergeant | 1970 |
| Timothy M. Martin | Sergeant | 1970 |

11. The following personnel have been promoted to the rank of Corporal:

| Name | Rank | Effective Date |
|---------------------|----------|----------------|
| Ulysses N. Mitchell | Corporal | 1970 |
| Vernon O. Nelson | Corporal | 1970 |
| Walter P. Phillips | Corporal | 1970 |
| Xavier Q. Quinn | Corporal | 1970 |
| Yvonne R. Reed | Corporal | 1970 |

12. The following personnel have been promoted to the rank of Private Second Class:

| Name | Rank | Effective Date |
|--------------------|----------------------|----------------|
| Zachary S. Smith | Private Second Class | 1970 |
| Adam T. Taylor | Private Second Class | 1970 |
| Brian U. Underhill | Private Second Class | 1970 |
| Carl V. Vance | Private Second Class | 1970 |
| Daniel W. Walker | Private Second Class | 1970 |

13. The following personnel have been promoted to the rank of Private Third Class:

| Name | Rank | Effective Date |
|---------------------|---------------------|----------------|
| Edward X. White | Private Third Class | 1970 |
| Fred Y. Young | Private Third Class | 1970 |
| Gerald Z. Zimmerman | Private Third Class | 1970 |
| Henry A. Adams | Private Third Class | 1970 |
| Ivan B. Baker | Private Third Class | 1970 |

14. The following personnel have been promoted to the rank of Sergeant First Class:

| Name | Rank | Effective Date |
|------------------|----------------------|----------------|
| Jack C. Clark | Sergeant First Class | 1970 |
| Kenneth D. Davis | Sergeant First Class | 1970 |
| Larry E. Evans | Sergeant First Class | 1970 |
| Michael F. Fox | Sergeant First Class | 1970 |
| Nathan G. Gibson | Sergeant First Class | 1970 |

15. The following personnel have been promoted to the rank of Sergeant Second Class:

| Name | Rank | Effective Date |
|----------------|-----------------------|----------------|
| Oliver H. Hall | Sergeant Second Class | 1970 |
| Paul I. Hill | Sergeant Second Class | 1970 |
| Quinn J. King | Sergeant Second Class | 1970 |
| Ronald K. Lamb | Sergeant Second Class | 1970 |
| Samuel L. Lee | Sergeant Second Class | 1970 |

16. The following personnel have been promoted to the rank of Sergeant Third Class:

| Name | Rank | Effective Date |
|---------------------|----------------------|----------------|
| Timothy M. Martin | Sergeant Third Class | 1970 |
| Ulysses N. Mitchell | Sergeant Third Class | 1970 |
| Vernon O. Nelson | Sergeant Third Class | 1970 |
| Walter P. Phillips | Sergeant Third Class | 1970 |
| Xavier Q. Quinn | Sergeant Third Class | 1970 |

17. The following personnel have been promoted to the rank of Sergeant Fourth Class:

| Name | Rank | Effective Date |
|--------------------|-----------------------|----------------|
| Yvonne R. Reed | Sergeant Fourth Class | 1970 |
| Zachary S. Smith | Sergeant Fourth Class | 1970 |
| Adam T. Taylor | Sergeant Fourth Class | 1970 |
| Brian U. Underhill | Sergeant Fourth Class | 1970 |
| Carl V. Vance | Sergeant Fourth Class | 1970 |

18. The following personnel have been promoted to the rank of Sergeant Fifth Class:

| Name | Rank | Effective Date |
|---------------------|----------------------|----------------|
| Daniel W. Walker | Sergeant Fifth Class | 1970 |
| Edward X. White | Sergeant Fifth Class | 1970 |
| Fred Y. Young | Sergeant Fifth Class | 1970 |
| Gerald Z. Zimmerman | Sergeant Fifth Class | 1970 |
| Henry A. Adams | Sergeant Fifth Class | 1970 |

19. The following personnel have been promoted to the rank of Sergeant Sixth Class:

| Name | Rank | Effective Date |
|------------------|----------------------|----------------|
| Ivan B. Baker | Sergeant Sixth Class | 1970 |
| Jack C. Clark | Sergeant Sixth Class | 1970 |
| Kenneth D. Davis | Sergeant Sixth Class | 1970 |
| Larry E. Evans | Sergeant Sixth Class | 1970 |
| Michael F. Fox | Sergeant Sixth Class | 1970 |

20. The following personnel have been promoted to the rank of Sergeant Seventh Class:

| Name | Rank | Effective Date |
|------------------|------------------------|----------------|
| Nathan G. Gibson | Sergeant Seventh Class | 1970 |
| Oliver H. Hall | Sergeant Seventh Class | 1970 |
| Paul I. Hill | Sergeant Seventh Class | 1970 |
| Quinn J. King | Sergeant Seventh Class | 1970 |
| Ronald K. Lamb | Sergeant Seventh Class | 1970 |

21. The following personnel have been promoted to the rank of Sergeant Eighth Class:

| Name | Rank | Effective Date |
|---------------------|-----------------------|----------------|
| Samuel L. Lee | Sergeant Eighth Class | 1970 |
| Timothy M. Martin | Sergeant Eighth Class | 1970 |
| Ulysses N. Mitchell | Sergeant Eighth Class | 1970 |
| Vernon O. Nelson | Sergeant Eighth Class | 1970 |
| Walter P. Phillips | Sergeant Eighth Class | 1970 |

22. The following personnel have been promoted to the rank of Sergeant Ninth Class:

| Name | Rank | Effective Date |
|--------------------|----------------------|----------------|
| Xavier Q. Quinn | Sergeant Ninth Class | 1970 |
| Yvonne R. Reed | Sergeant Ninth Class | 1970 |
| Zachary S. Smith | Sergeant Ninth Class | 1970 |
| Adam T. Taylor | Sergeant Ninth Class | 1970 |
| Brian U. Underhill | Sergeant Ninth Class | 1970 |

23. The following personnel have been promoted to the rank of Sergeant Tenth Class:

| Name | Rank | Effective Date |
|---------------------|----------------------|----------------|
| Carl V. Vance | Sergeant Tenth Class | 1970 |
| Daniel W. Walker | Sergeant Tenth Class | 1970 |
| Edward X. White | Sergeant Tenth Class | 1970 |
| Fred Y. Young | Sergeant Tenth Class | 1970 |
| Gerald Z. Zimmerman | Sergeant Tenth Class | 1970 |

24. The following personnel have been promoted to the rank of Sergeant Eleventh Class:

| Name | Rank | Effective Date |
|------------------|-------------------------|----------------|
| Henry A. Adams | Sergeant Eleventh Class | 1970 |
| Ivan B. Baker | Sergeant Eleventh Class | 1970 |
| Jack C. Clark | Sergeant Eleventh Class | 1970 |
| Kenneth D. Davis | Sergeant Eleventh Class | 1970 |
| Larry E. Evans | Sergeant Eleventh Class | 1970 |

25. The following personnel have been promoted to the rank of Sergeant Twelfth Class:

| Name | Rank | Effective Date |
|------------------|------------------------|----------------|
| Michael F. Fox | Sergeant Twelfth Class | 1970 |
| Nathan G. Gibson | Sergeant Twelfth Class | 1970 |
| Oliver H. Hall | Sergeant Twelfth Class | 1970 |
| Paul I. Hill | Sergeant Twelfth Class | 1970 |
| Quinn J. King | Sergeant Twelfth Class | 1970 |

26. The following personnel have been promoted to the rank of Sergeant Thirteenth Class:

| Name | Rank | Effective Date |
|---------------------|---------------------------|----------------|
| Ronald K. Lamb | Sergeant Thirteenth Class | 1970 |
| Samuel L. Lee | Sergeant Thirteenth Class | 1970 |
| Timothy M. Martin | Sergeant Thirteenth Class | 1970 |
| Ulysses N. Mitchell | Sergeant Thirteenth Class | 1970 |
| Vernon O. Nelson | Sergeant Thirteenth Class | 1970 |

27. The following personnel have been promoted to the rank of Sergeant Fourteenth Class:

| Name | Rank | Effective Date |
|--------------------|---------------------------|----------------|
| Walter P. Phillips | Sergeant Fourteenth Class | 1970 |
| Xavier Q. Quinn | Sergeant Fourteenth Class | 1970 |
| Yvonne R. Reed | Sergeant Fourteenth Class | 1970 |
| Zachary S. Smith | Sergeant Fourteenth Class | 1970 |
| Adam T. Taylor | Sergeant Fourteenth Class | 1970 |

28. The following personnel have been promoted to the rank of Sergeant Fifteenth Class:

| Name | Rank | Effective Date |
|--------------------|--------------------------|----------------|
| Brian U. Underhill | Sergeant Fifteenth Class | 1970 |
| Carl V. Vance | Sergeant Fifteenth Class | 1970 |
| Daniel W. Walker | Sergeant Fifteenth Class | 1970 |
| Edward X. White | Sergeant Fifteenth Class | 1970 |
| Fred Y. Young | Sergeant Fifteenth Class | 1970 |

29. The following personnel have been promoted to the rank of Sergeant Sixteenth Class:

| Name | Rank | Effective Date |
|---------------------|--------------------------|----------------|
| Gerald Z. Zimmerman | Sergeant Sixteenth Class | 1970 |
| Henry A. Adams | Sergeant Sixteenth Class | 1970 |
| Ivan B. Baker | Sergeant Sixteenth Class | 1970 |
| Jack C. Clark | Sergeant Sixteenth Class | 1970 |
| Kenneth D. Davis | Sergeant Sixteenth Class | 1970 |

30. The following personnel have been promoted to the rank of Sergeant Seventeenth Class:

| Name | Rank | Effective Date |
|------------------|----------------------------|----------------|
| Larry E. Evans | Sergeant Seventeenth Class | 1970 |
| Michael F. Fox | Sergeant Seventeenth Class | 1970 |
| Nathan G. Gibson | Sergeant Seventeenth Class | 1970 |
| Oliver H. Hall | Sergeant Seventeenth Class | 1970 |
| Paul I. Hill | Sergeant Seventeenth Class | 1970 |

31. The following personnel have been promoted to the rank of Sergeant Eighteenth Class:

| Name | Rank | Effective Date |
|---------------------|---------------------------|----------------|
| Quinn J. King | Sergeant Eighteenth Class | 1970 |
| Ronald K. Lamb | Sergeant Eighteenth Class | 1970 |
| Samuel L. Lee | Sergeant Eighteenth Class | 1970 |
| Timothy M. Martin | Sergeant Eighteenth Class | 1970 |
| Ulysses N. Mitchell | Sergeant Eighteenth Class | 1970 |

32. The following personnel have been promoted to the rank of Sergeant Nineteenth Class:

| Name | Rank | Effective Date |
|--------------------|---------------------------|----------------|
| Vernon O. Nelson | Sergeant Nineteenth Class | 1970 |
| Walter P. Phillips | Sergeant Nineteenth Class | 1970 |
| Xavier Q. Quinn | Sergeant Nineteenth Class | 1970 |
| Yvonne R. Reed | Sergeant Nineteenth Class | 1970 |
| Zachary S. Smith | Sergeant Nineteenth Class | 1970 |

33. The following personnel have been promoted to the rank of Sergeant Twentieth Class:

| Name | Rank | Effective Date |
|--------------------|--------------------------|----------------|
| Adam T. Taylor | Sergeant Twentieth Class | 1970 |
| Brian U. Underhill | Sergeant Twentieth Class | 1970 |
| Carl V. Vance | Sergeant Twentieth Class | 1970 |
| Daniel W. Walker | Sergeant Twentieth Class | 1970 |
| Edward X. White | Sergeant Twentieth Class | 1970 |

34. The following personnel have been promoted to the rank of Sergeant Twenty-first Class:

| Name | Rank | Effective Date |
|---------------------|-----------------------------|----------------|
| Fred Y. Young | Sergeant Twenty-first Class | 1970 |
| Gerald Z. Zimmerman | Sergeant Twenty-first Class | 1970 |
| Henry A. Adams | Sergeant Twenty-first Class | 1970 |
| Ivan B. Baker | Sergeant Twenty-first Class | 1970 |
| Jack C. Clark | Sergeant Twenty-first Class | 1970 |

35. The following personnel have been promoted to the rank of Sergeant Twenty-second Class:

| Name | Rank | Effective Date |
|------------------|------------------------------|----------------|
| Kenneth D. Davis | Sergeant Twenty-second Class | 1970 |
| Larry E. Evans | Sergeant Twenty-second Class | 1970 |
| Michael F. Fox | Sergeant Twenty-second Class | 1970 |
| Nathan G. Gibson | Sergeant Twenty-second Class | 1970 |
| Oliver H. Hall | Sergeant Twenty-second Class | 1970 |

36. The following personnel have been promoted to the rank of Sergeant Twenty-third Class:

| Name | Rank | Effective Date |
|-------------------|-----------------------------|----------------|
| Paul I. Hill | Sergeant Twenty-third Class | 1970 |
| Quinn J. King | Sergeant Twenty-third Class | 1970 |
| Ronald K. Lamb | Sergeant Twenty-third Class | 1970 |
| Samuel L. Lee | Sergeant Twenty-third Class | 1970 |
| Timothy M. Martin | Sergeant Twenty-third Class | 1970 |

37. The following personnel have been promoted to the rank of Sergeant Twenty-fourth Class:

| Name | Rank | Effective Date |
|---------------------|------------------------------|----------------|
| Ulysses N. Mitchell | Sergeant Twenty-fourth Class | 1970 |
| Vernon O. Nelson | Sergeant Twenty-fourth Class | 1970 |
| Walter P. Phillips | Sergeant Twenty-fourth Class | 1970 |
| Xavier Q. Quinn | Sergeant Twenty-fourth Class | 1970 |
| Yvonne R. Reed | Sergeant Twenty-fourth Class | 1970 |

38. The following personnel have been promoted to the rank of Sergeant Twenty-fifth Class:

| Name | Rank | Effective Date |
|--------------------|-----------------------------|----------------|
| Zachary S. Smith | Sergeant Twenty-fifth Class | 1970 |
| Adam T. Taylor | Sergeant Twenty-fifth Class | 1970 |
| Brian U. Underhill | Sergeant Twenty-fifth Class | 1970 |
| Carl V. Vance | Sergeant Twenty-fifth Class | 1970 |
| Daniel W. Walker | Sergeant Twenty-fifth Class | 1970 |

39. The following personnel have been promoted to the rank of Sergeant Twenty-sixth Class:

| Name | Rank | Effective Date |
|---------------------|-----------------------------|----------------|
| Edward X. White | Sergeant Twenty-sixth Class | 1970 |
| Fred Y. Young | Sergeant Twenty-sixth Class | 1970 |
| Gerald Z. Zimmerman | Sergeant Twenty-sixth Class | 1970 |
| Henry A. Adams | Sergeant Twenty-sixth Class | 1970 |
| Ivan B. Baker | Sergeant Twenty-sixth Class | 1970 |

40. The following personnel have been promoted to the rank of Sergeant Twenty-seventh Class:

| Name | Rank | Effective Date |
|------------------|-------------------------------|----------------|
| Jack C. Clark | Sergeant Twenty-seventh Class | 1970 |
| Kenneth D. Davis | Sergeant Twenty-seventh Class | 1970 |
| Larry E. Evans | Sergeant Twenty-seventh Class | 1970 |
| Michael F. Fox | Sergeant Twenty-seventh Class | 1970 |
| Nathan G. Gibson | Sergeant Twenty-seventh Class | 1970 |

41. The following personnel have been promoted to the rank of Sergeant Twenty-eighth Class:

| Name | Rank | Effective Date |
|----------------|------------------------------|----------------|
| Oliver H. Hall | Sergeant Twenty-eighth Class | 1970 |
| Paul I. Hill | Sergeant Twenty-eighth Class | 1970 |
| Quinn J. King | Sergeant Twenty-eighth Class | 1970 |
| Ronald K. Lamb | Sergeant Twenty-eighth Class | 1970 |
| Samuel L. Lee | Sergeant Twenty-eighth Class | 1970 |

42. The following personnel have been promoted to the rank of Sergeant Twenty-ninth Class:

| Name | Rank | Effective Date |
|---------------------|-----------------------------|----------------|
| Timothy M. Martin | Sergeant Twenty-ninth Class | 1970 |
| Ulysses N. Mitchell | Sergeant Twenty-ninth Class | 1970 |
| Vernon O. Nelson | Sergeant Twenty-ninth Class | 1970 |
| Walter P. Phillips | Sergeant Twenty-ninth Class | 1970 |
| Xavier Q. Quinn | Sergeant Twenty-ninth Class | 1970 |

43. The following personnel have been promoted to the rank of Sergeant Thirtieth Class:

| Name | Rank | Effective Date |
|--------------------|--------------------------|----------------|
| Yvonne R. Reed | Sergeant Thirtieth Class | 1970 |
| Zachary S. Smith | Sergeant Thirtieth Class | 1970 |
| Adam T. Taylor | Sergeant Thirtieth Class | 1970 |
| Brian U. Underhill | Sergeant Thirtieth Class | 1970 |
| Carl V. Vance | Sergeant Thirtieth Class | 1970 |

44. The following personnel have been promoted to the rank of Sergeant Thirty-first Class:

| Name | Rank | Effective Date |
|---------------------|-----------------------------|----------------|
| Daniel W. Walker | Sergeant Thirty-first Class | 1970 |
| Edward X. White | Sergeant Thirty-first Class | 1970 |
| Fred Y. Young | Sergeant Thirty-first Class | 1970 |
| Gerald Z. Zimmerman | Sergeant Thirty-first Class | 1970 |
| Henry A. Adams | Sergeant Thirty-first Class | 1970 |

45. The following personnel have been promoted to the rank of Sergeant Thirty-second Class:

| Name | Rank | Effective Date |
|------------------|------------------------------|----------------|
| Ivan B. Baker | Sergeant Thirty-second Class | 1970 |
| Jack C. Clark | Sergeant Thirty-second Class | 1970 |
| Kenneth D. Davis | Sergeant Thirty-second Class | 1970 |
| Larry E. Evans | Sergeant Thirty-second Class | 1970 |
| Michael F. Fox | Sergeant Thirty-second Class | 1970 |

46. The following personnel have been promoted to the rank of Sergeant Thirty-third Class:

| Name | Rank | Effective Date |
|------------------|-----------------------------|----------------|
| Nathan G. Gibson | Sergeant Thirty-third Class | 1970 |
| Oliver H. Hall | Sergeant Thirty-third Class | 1970 |
| Paul I. Hill | Sergeant Thirty-third Class | 1970 |
| Quinn J. King | Sergeant Thirty-third Class | 1970 |
| Ronald K. Lamb | Sergeant Thirty-third Class | 1970 |

47. The following personnel have been promoted to the rank of Sergeant Thirty-fourth Class:

| Name | Rank | Effective Date |
|---------------------|------------------------------|----------------|
| Samuel L. Lee | Sergeant Thirty-fourth Class | 1970 |
| Timothy M. Martin | Sergeant Thirty-fourth Class | 1970 |
| Ulysses N. Mitchell | Sergeant Thirty-fourth Class | 1970 |
| Vernon O. Nelson | Sergeant Thirty-fourth Class | 1970 |
| Walter P. Phillips | Sergeant Thirty-fourth Class | 1970 |

48. The following personnel have been promoted to the rank of Sergeant Thirty-fifth Class:

| Name | Rank | Effective Date |
|--------------------|-----------------------------|----------------|
| Xavier Q. Quinn | Sergeant Thirty-fifth Class | 1970 |
| Yvonne R. Reed | Sergeant Thirty-fifth Class | 1970 |
| Zachary S. Smith | Sergeant Thirty-fifth Class | 1970 |
| Adam T. Taylor | Sergeant Thirty-fifth Class | 1970 |
| Brian U. Underhill | Sergeant Thirty-fifth Class | 1970 |

49. The following personnel have been promoted to the rank of Sergeant Thirty-sixth Class:

| Name | Rank | Effective Date |
|---------------------|-----------------------------|----------------|
| Carl V. Vance | Sergeant Thirty-sixth Class | 1970 |
| Daniel W. Walker | Sergeant Thirty-sixth Class | 1970 |
| Edward X. White | Sergeant Thirty-sixth Class | 1970 |
| Fred Y. Young | Sergeant Thirty-sixth Class | 1970 |
| Gerald Z. Zimmerman | Sergeant Thirty-sixth Class | 1970 |

50. The following personnel have been promoted to the rank of Sergeant Thirty-seventh Class:

| Name | Rank | Effective Date |
|------------------|-------------------------------|----------------|
| Henry A. Adams | Sergeant Thirty-seventh Class | 1970 |
| Ivan B. Baker | Sergeant Thirty-seventh Class | 1970 |
| Jack C. Clark | Sergeant Thirty-seventh Class | 1970 |
| Kenneth D. Davis | Sergeant Thirty-seventh Class | 1970 |
| Larry E. Evans | Sergeant Thirty-seventh Class | 1970 |

51. The following personnel have been promoted to the rank of Sergeant Thirty-eighth Class:

| Name | Rank | Effective Date |
|------------------|------------------------------|----------------|
| Michael F. Fox | Sergeant Thirty-eighth Class | 1970 |
| Nathan G. Gibson | Sergeant Thirty-eighth Class | 1970 |
| Oliver H. Hall | Sergeant Thirty-eighth Class | 1970 |
| Paul I. Hill | Sergeant Thirty-eighth Class | 1970 |
| Quinn J. King | Sergeant Thirty-eighth Class | 1970 |

52. The following personnel have been promoted to the rank of Sergeant Thirty-ninth Class:

| Name | Rank | Effective Date |
|---------------------|-----------------------------|----------------|
| Ronald K. Lamb | Sergeant Thirty-ninth Class | 1970 |
| Samuel L. Lee | Sergeant Thirty-ninth Class | 1970 |
| Timothy M. Martin | Sergeant Thirty-ninth Class | 1970 |
| Ulysses N. Mitchell | Sergeant Thirty-ninth Class | 1970 |
| Vernon O. Nelson | Sergeant Thirty-ninth Class | 1970 |

53. The following personnel have been promoted to the rank of Sergeant Fortieth Class:

| Name | Rank | Effective Date |
|--------------------|-------------------------|----------------|
| Walter P. Phillips | Sergeant Fortieth Class | 1970 |
| Xavier Q. Quinn | Sergeant Fortieth Class | 1970 |
| Yvonne R. Reed | Sergeant Fortieth Class | 1970 |
| Zachary S. Smith | Sergeant Fortieth Class | 1970 |
| Adam T. Taylor | Sergeant Fortieth Class | 1970 |

54. The following personnel have been promoted to the rank of Sergeant Forty-first Class:

| Name | Rank | Effective Date |
|--------------------|----------------------------|----------------|
| Brian U. Underhill | Sergeant Forty-first Class | 1970 |
| Carl V. Vance | Sergeant Forty-first Class | 1970 |
| Daniel W. Walker | Sergeant Forty-first Class | 1970 |
| Edward X. White | Sergeant Forty-first Class | 1970 |
| Fred Y. Young | Sergeant Forty-first Class | 1970 |

55. The following personnel have been promoted to the rank of Sergeant Forty-second Class:

| Name | Rank | Effective Date |
|---------------------|-----------------------------|----------------|
| Gerald Z. Zimmerman | Sergeant Forty-second Class | 1970 |
| Henry A. Adams | Sergeant Forty-second Class | 1970 |
| Ivan B. Baker | Sergeant Forty-second Class | 1970 |
| Jack C. Clark | Sergeant Forty-second Class | 1970 |
| Kenneth D. Davis | Sergeant Forty-second Class | 1970 |

56. The following personnel have been promoted to the rank of Sergeant Forty-third Class:

| Name | Rank | Effective Date |
|------------------|----------------------------|----------------|
| Larry E. Evans | Sergeant Forty-third Class | 1970 |
| Michael F. Fox | Sergeant Forty-third Class | 1970 |
| Nathan G. Gibson | Sergeant Forty-third Class | 1970 |
| Oliver H. Hall | Sergeant Forty-third Class | 1970 |
| Paul I. Hill | Sergeant Forty-third Class | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16710

16704

| | | | | | | | |
|---|--|--|---|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY St. Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | | c. LENGTH OF STAY IN lb
3½ yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Maddox | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rosewood State Hospital | | | | d. STREET ADDRESS
- | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Deborah Mae VALLANDINGHAM | | | | 4. DATE OF DEATH
Month 12 Day 12 Year 19 67 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1-4-57 | |
| 9. AGE (In years last birthday)
10 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dependent | | 11. BIRTHPLACE (State or foreign country)
St. Mary's Co., Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William Laurence Vallandingham | | | | 14. MOTHER'S MAIDEN NAME
Mary Helen Thomas | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Rosewood Records, Owings Mills, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Tracheal Bronchial Obstruction, mucous plug
DUE TO (b) Bronchial Pneumonia, right lung
DUE TO (c) Acute Hemorrhagic Bronchitis
500 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
Terminal
10 days
10 days | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Institutionalization due to severe mental retardation. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 12 noon p.m. 12/12 19 67 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Spas. 3 - Rosw. St. Hosp. Owings Mills, Balto., Md. | |
| 20f. (City or town) (County) (State)
Owings Mills, Balto., Md. | | | | | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
D.D. Caples | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) D.D. Caples, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | Address (Street, city, town, or county) Reisterstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/15/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart | | 23d. LOCATION (City or Town) (County) (State)
Bushwood Md | |
| 24. FUNERAL DIRECTOR
W. Clarke Mattingley | | | | 25a. REC'D BY REGISTRAR
DEC 15 1967 | | 25b. REGISTRAR'S SIGNATURE
John A. Jones | |

• • • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|----------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 16711 | | CERTIFICATE OF DEATH | |
| 16705 | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | c. LENGTH OF STAY IN 1b
<u>03-1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Towson Convalescent Home</u>
<u>301 Chesapeake Ave</u> | | d. STREET ADDRESS
<u>214 Regester Ave</u> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Sarah</u> Middle <u>E</u> Last <u>Vickers</u> | | 4. DATE OF DEATH
Month <u>12</u> Day <u>22</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 14, 1883</u> |
| 9. AGE (In years lost birthday)
<u>84 yrs.</u> | | IF UNDER 1 YEAR
Months <u>12</u> Days <u>22</u> Hours <u>19</u> Min. <u>67</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Kent. Co. Md.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Kent. Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>Kent. Co. Md.</u> | |
| 13. FATHER'S NAME
<u>Benjamin F. Morris</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Jane Gooding</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Mrs Margaret Huegelmeyer</u> | | Address
<u>214 Regester Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4200</u> IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
DUE TO (b) <u>Arteriosclerotic H.D.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>a.m.</u> <u>19</u> p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>August, 1961</u> , to <u>12-22-1967</u> that (I) (we) last saw the deceased alive on <u>12-18-1967</u> , and that death occurred at <u>12:00 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>K A Petrucci</u> | | 22b. DATE SIGNED
<u>12-24-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>K A Petrucci</u> | | 22d. ADDRESS
<u>100 W. University Pkwy 21210</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>12/26/1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR
<u>Mitchell-Wiedefeld Home</u> | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 29 1967</u> | |
| ADDRESS
<u>6500 York Rd.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

14702

RECORD OF DEATH

14702

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CERTIFICATE OF DEATH

16712

16706

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY --- | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
PIKESVILLE | | c. LENGTH OF STAY IN 1b
30-4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MILFORD MANOR NURSING HOME, MILFORD MILL RD 7000 FIELDCREST ROAD #21215 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
GERTRUDE VINE | | 4. DATE OF DEATH
Month Day Year
DECEMBER 3, 1967 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
78 yrs. |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 9b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 10a. BIRTHPLACE (County & State, or foreign country)
RUSSIA | | 10b. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. FATHER'S NAME
? DAVITZ | | 12. MOTHER'S MAIDEN NAME
EDITH ? | |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO | | 14. SOCIAL SECURITY NO.
NO | |
| 15. INFORMANT
MRS. EDITH FINE, 5805 CROSS COUNTRY BLVD. #9 | | Address APT. C | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1992 IMMEDIATE CAUSE (a) Sarcoma with metastasis
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
1 yr + |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
no | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1/6, 1963 to 12/3, 1967 that (I) (we) last saw the deceased alive on 12/3 1967 , and that death occurred at 10:30M , from causes and on the date stated above | | | |
| 22a. SIGNATURE
Maurice Feldman | | 22b. DATE SIGNED
12/4/67 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. MAURICE FELDMAN | | 22d. ADDRESS
6610 CROSS COUNTRY BLVD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
12-5-67 | 23c. NAME OF CEMETERY OR CREMATORY
BETH EL MEMORIAL PARK | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., INC., 6010 REISTERSTOWN ROAD | | 25a. REC'D. BY REGISTRAR
DEC 8 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1871

1870

CENTRAL OF CALIF.

BALTIMORE

WILMINGTON

BALTIMORE

ALLEGEDLY, HAVING BEEN IN THE CITY OF BALTIMORE, MARYLAND, IN THE MONTH OF JANUARY, 1871.

FEMALE WHITE

VINE

CENTRAL

WILMINGTON

AT HOME

RUSSIA

DAVID

EDITH

NO

EDITH, THE DAUGHTER OF DAVID, WAS BORN IN THE CITY OF BALTIMORE, MARYLAND, IN THE MONTH OF JANUARY, 1871.

NO. WHITE FEMALE

EDITH CROSS COUNTRY CLUB

POSTAL

1871-72

BEING AN ANNUAL REPORT

BALTIMORE, MARYLAND

FOR THE YEAR 1871, AND THE FIRST YEAR OF THE NEW CENTURY CLUB.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore County</u>
<u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Balt. City</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Mount Wilson</u> | | c. LENGTH OF STAY IN 1b
<u>30.4</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Mount Wilson State Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Leonard Morthy Von Schroeder</u> | | 4. DATE OF DEATH
Month <u>December</u> Day <u>12</u> Year <u>67</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>August 11, 1900</u> |
| 9. AGE (In years last birthday)
<u>67</u> yrs. | | IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | |
| 13. FATHER'S NAME
<u>George Von Schroeder</u> | | 14. MOTHER'S MAIDEN NAME
<u>Anna Poffemberger</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>Unknown</u> | | 16. SOCIAL SECURITY NO.
<u>183-12-7512</u> | |
| 17. INFORMANT
<u>Records, Mt. Wilson State Hospital</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>527.1</u> IMMEDIATE CAUSE (a) <u>Heart failure</u>
DUE TO
(b) <u>Cor Pulmonale</u>
DUE TO
(c) <u>Pulmonary Emphysema</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>Two years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>002.1</u> <u>XXXXXX</u> <u>Far Advanced Pulmonary Tuberculosis</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>0</u> a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>September 21, 1967</u> to <u>December 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>December 12, 1967</u> , and that death occurred at <u>5:00 P.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Wm. Newcomer</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Wm. Newcomer, M.D., Superintendent</u> | | 22d. ADDRESS
<u>Mount Wilson, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
<u>12-18-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>W. & M. M. School</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>B. Newcomer</u> | | 25a. REC'D BY REGISTRAR
<u>DEC 20 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

1941

California

Home Wagon

Home Wagon State Hospital

W

1941 Records, Home Wagon State Hospital

Mr. Lawrence, H.P., Superintendent Home Wagon, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|---|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 604 W. JOPPA ROAD | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTO.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON
d. STREET ADDRESS 604 W. JOPPA ROAD
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) John T. Waldhauser Jr. | | 4. DATE OF DEATH DEC. 28 19 67 | | 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER - RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY LAW | | 11. BIRTHPLACE (County & State, or foreign country) NEW YORK | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME JOHN T. WALDHAUSER SR. | | 14. MOTHER'S MAIEN NAME MARGARET BOWLING | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 220-44-2480 | | 17. INFIRMANT FAMILY RECORDS | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from JAN 2nd , 19 58 , to Dec 28 , 19 67 , that (I) (we) last saw the deceased alive on Dec 27th 19 67 , and that death occurred at 2:37 PM , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE John X. Quinn | | | | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12/29/67 | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 12/30/67 | | 23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL | | 23d. LOCATION (City, town or county) (State) BALTO. CITY MD. | | | |
| 24. FUNERAL DIRECTOR John Burns And Sons Towson | | | | ADDRESS | | 25a. REC'D BY REGISTRAR Charles Judge | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | DATE JAN 3 1968 | | | | | |

1918

CERTIFICATE OF DEATH

1918

DATE

PLACE

TO

FROM

DEATH

CAUSE

AGE

SEX

RESIDENCE

DATE

PLACE

DEATH

CAUSE

AGE

SEX

RESIDENCE

DATE

PLACE

DEATH

CAUSE

AGE

SEX

RESIDENCE

DATE

PLACE

DEATH

CAUSE

AGE

SEX

RESIDENCE

DATE

PLACE

DEATH

CAUSE

CERTIFICATE OF DEATH

16709

16715

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Essex</u> | | c. LENGTH OF STAY IN lb
<u>3 mo</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Middle River</u> 03-1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Gray Hall Nursing Home</u> | | | | d. STREET ADDRESS
<u>1416 Wilson Point Rd</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Margaret E.</u> Middle <u>Walker</u> Last <u>Walker</u> | | | | 4. DATE OF DEATH
Month <u>12</u> Day <u>30</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>9/7/1982</u> | |
| 9. AGE (In years lost birthday) yrs.
<u>85</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Domestic Work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Private Home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | 13. FATHER'S NAME
<u>James Turner</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Lucie Varina</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>220-30-3648</u> | | | | 17. INFORMANT
<u>Joseph Floyd</u> Address <u>1416 Wilson Point Rd.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4221</u>
DUE TO (b) <u>ASCVD</u>
DUE TO (c) <u>?</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>?</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>0</u> a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> , 19 <u>67</u> , to <u>12/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/29</u> , 19 <u>67</u> , and that death occurred at <u>3 P</u> M, from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Hudson Fesche</u> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>12/29/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Hudson Fesche</u> | | | | 22d. ADDRESS
<u>University Hosp.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Buried</u> | | 23b. DATE THEREOF
<u>1/12/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Landon Park Cem.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, md.</u> | |
| 24. FUNERAL DIRECTOR
<u>John J. ...</u> | | | | 25a. JANUARY 1968
<u>90 Collins St.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1070

REMARKS ON DEATH

1070



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16716

16710

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN lb
42 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS
418 PITTSBURG AVENUE | |
| 3. NAME OF DECEASED
(Type or print)
First DAVID Middle LEE Last WALLS | | 4. DATE OF DEATH
Month DECEMBER Day 23 Year 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGROID | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7 3 17 |
| 9. AGE (In years lost birthday)
50 yrs. | | IF UNDER 1 YEAR Months Days Hours Min.
19 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NURSING ASS'T | | 10b. KIND OF BUSINESS OR INDUSTRY
HOSPITAL | 11. BIRTHPLACE (County & State, or foreign country)
YORK CO., S.C. |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
ELIHUE WALLS | |
| 14. MOTHER'S MAIDEN NAME
EMMA JANE DAVIS | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW II | |
| 16. SOCIAL SECURITY NO.
249 22 09 90 | | 17. INFORMANT
CLINICAL RECORDS VA HOSP FT HOWARD, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) C.V.A. (THROMBOSIS OF RT MIDDLE CEREBRAL ARTERY)
332X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
- |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour "a.m." p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11 11 67 , 19__, to 12 23 67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12 23 67 , 19__, and that death occurred at 1:30AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
B.R. KRISHNA MURTHY M.D. | | 22b. DATE SIGNED
12 23 67 | |
| 22c. PHYSICIAN'S NAME (Type)
B.R. KRISHNA MURTHY | | 22d. ADDRESS
VA HOSPITAL FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
12-28-67 | 23c. NAME OF CEMETERY OR CREMATORY
ROCK GROVE CHURCH | 23d. LOCATION (City or Town) (County) (State)
ROCK HILL, S.C. |
| 24. FUNERAL DIRECTOR
MORTON DYETT FUNERAL HOME, 1701 LAURENS | | 25a. REC'D BY REGISTRAR
DEC 28 1967 | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1971

1971

MARYLAND

BALTIMORE

BALTIMORE

42 DAYS

FORT HOWARD

418 PITTSBURG AVENUE

VETERANS ADMINISTRATION HOSPITAL

07 DECEMBER 22

WALLS

LEE

DAVID

50

7 3 17

X

MICHAEL

MALE

USA

YORK CO., S.C.

HOSPITAL

NURSING ASSIST

EMMA JANE DAVIS

ELIUS WALLS

249 32 09 90 CLINICAL RECORDS AND X-RAY, FORT HOWARD, MD

WE 11

YRS

C.V.A. (THROMBOSIS OF RT MIDDLE CEREBRAL ARTERY) -

X

12 23 67

11 11 67

1:30

12 23 67

X

X 12 23 67

VA HOSPITAL FORT HOWARD, MARYLAND

S.A. KRISHNA MURTHY

ROCK HILL, S.C.

ROCK GROVE CHURCH

BALTO, MD

NORTON DUFFY MINERAL HOME, 1701 LAURENS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

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| <div>16711</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>16711</div> | | | | | | | | | | | |
|---|--|-------------------------------|-------------------------------------|---|------------------------------------|---|--|--|------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md.
b. COUNTY | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mount Wilson | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Mount Wilson State Hospital | | | | | | d. STREET ADDRESS
1228 Caroline St | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
DANIEL | | | First | | | Middle
WASHINGTON | | | Last | | |
| 4. DATE OF DEATH
Month
DEC. | | Day
4 | | Year
1967 | | | | | | | |
| 5. SEX
M. | | 6. COLOR OR RACE
N. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5-16-1894 | | 9. AGE (In years last birthday)
73 yrs | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | | | 10b. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION | | | | 11. BIRTHPLACE (County & State, or foreign country)
SOUTH CAROLINA - JAMESTOWN | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
ELIAS WASHINGTON | | | | | | 14. MOTHER'S MAIDEN NAME
HATTIE MILLER | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
Records, Mt. Wilson State Hospital | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIO SCLEROTIC HEART DISEASE
(c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-19-1967 , to 12-4-1967 , that (I) (we) last saw the deceased alive on 12-4-67 19, and that death occurred on 11-15-AM , from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
W. Newcomer | | | | | | | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
Wm. Newcomer, M.D., Superintendent | | | | | | 22d. ADDRESS
Mount Wilson, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | | | 23b. DATE THEREOF
12-8-67 | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State)
MONKS CORNER, S.C. | | | |
| 24. FUNERAL DIRECTOR
Elliot Fun. Home | | | | | | ADDRESS
1129 N. Caroline | | 25a. REC'D BY REGISTRAR
DEC 8 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judson | |

1941

Baltimore

Mount Wilson

Mount Wilson State Hospital

8/13

Records, Mt. Wilson State Hospital

Dr. Howson, M.D., Superintendent, Mount Wilson, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--------------------------------------|--|--|--|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 16718 CERTIFICATE OF DEATH 16712 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | | c. LENGTH OF STAY IN 1b
10 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VA HOSPITAL, FORT HOWARD, MARYLAND | | | | | | d. STREET ADDRESS
1603 MILLER STREET | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JESSIE Middle WASHINGTON Last WASHINGTON | | | | | | 4. DATE OF DEATH
Month DECEMBER Day 10 Year 1967 | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
NEGRO | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1/15/96 | | 9. AGE (In years lost birthday)
71 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
COOK | | | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JAMES WASHINGTON | | | | | | 14. MOTHER'S MAIDEN NAME
SARAH KUCKIES | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | | | 16. SOCIAL SECURITY NO.
218 05 01 96 | | 17. INFORMANT
CLINICAL RECORDS, VA HOSP, FORT HOWARD, MARYLAND Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC CARCINOMA REGIONAL LYMPH NODES, LUNGS AND LIVER
(c) SURGICAL ABSENCE, LARYNX
INTERVAL BETWEEN ONSET AND DEATH
RECENT | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/1/67 , 19__, to 12/10/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/10/67 , 19__, and that death occurred at 7:45PM , from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<i>George C. McElpatrick</i>
22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D. | | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
12/11/67 | | 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12-15-67 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS
COLLICK FUNERAL HOME
2400 E. Oliver St. Baltimore, Md. | | 25a. REC'D BY REGISTRAR
DATE DEC 12 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

22701

DECEMBER

GARY TRIN

2740 OF

VA HOSPITAL, FORT HOWARD, MARYLAND

1603 MILLER STREET

16221E

WASHING

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152/90

17

2000

BALTIMORE, MARYLAND

A. 3. U

JAMES W. H. WILSON

SARAH WICKLES

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218 02 01 00 CLINICAL RECORDS

15107

TO VISE

50/50/50

2

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16719

16714

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
e. COUNTY
Baltimore
MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE
Maryland
b. COUNTY
Baltimore | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Reisterstown | | | | c. LENGTH OF STAY IN b.
5 months | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Bent Nursing Home | | | | d. STREET ADDRESS
4203 Springdale Ave. | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Grace Edna Waters | | | | 4. DATE OF DEATH
Month Day Year
December 14 19 67 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 30, 1897 | |
| 9. AGE (In years last birthday)
70 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (County & State, or foreign country)
Washington Co., Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
John Z. Draper | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
213-50-2951 | | | |
| 17. INFORMANT
Mrs. Aaron Seidler | | | | Address
811 Painted Post Ct. Baltimore, Md. 21208 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal Aneurysm - ruptured
451X DUE TO (b) Arteriosclerosis - generalized
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
INTERVAL BETWEEN ONSET AND DEATH
1 week
Year | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 23, 1967 to December 14, 1967 , that (I) (we) last saw the deceased alive on December 14, 1967 , and that death occurred at 10 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Clarence E. McWilliams M.D. | | | | 22b. DATE SIGNED
December 14, 1967 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Clarence E. McWilliams | | | | 22d. ADDRESS
11904 Reisterstown Rd. Reisterstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/18/67 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Paul Cemetery | | 23d. LOCATION (City, town or county) (State)
Washington Co., Md. | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
H. J. Sechardt | | | | 25a. REC'D BY REGISTRAR
DEC 19 1967 | | | |
| ADDRESS
Owings Mills, Md. | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Charles E. Williams

24. 4th Company

United States Army

H. J. Abbott

24. 4th Company

Washington D. C.

Charles E. Williams

24. 4th Company

United States Army

H. J. Abbott

24. 4th Company

Washington D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16720

16715

| | | | |
|---|--------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LUTHERVILLE MARYLAND | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
GREATER BALTIMORE MED. CENTRE | | d. STREET ADDRESS
805 JAMISON Rd. | |
| 3. NAME OF DECEASED
(Type or print)
First ADOLPH Middle WEBER Last WEBER | | 4. DATE OF DEATH
Month Dec Day 1 Year 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
CUU | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-18-1897 |
| 9. AGE (In years last birthday) yrs. 70 | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY
— | |
| 11. BIRTHPLACE (County & State, or foreign country)
CINCINNATI, OHIO | | 12. CITIZEN OF WHAT COUNTRY
US | |
| 13. FATHER'S NAME
ADOLPH WEBER | | 14. MOTHER'S MAIDEN NAME
MOSN RUGGER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
206-07-4899 | | 16. SOCIAL SECURITY NO.
206-07-4899 | |
| 17. INFORMANT
PT. CHART | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple myeloma
DUE TO 203X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) —
DUE TO —
(c) — | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 24th , 19 67 , to Dec 1st , 19 67 , that (I) (we) last saw the deceased alive on Dec 1st , 19 67 , and that death occurred at 2:33 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Duncan McGhie | | 22b. DATE SIGNED
Dec 1st 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
DUNCAN MCGHIE | | 22d. ADDRESS
616 E 34th St. Balto Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12-4-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. Francis Xavier | | 23d. LOCATION (City or Town) (County) (State)
Willard, Ohio | |
| 24. FUNERAL DIRECTOR
Will. Cook-Brooks | | 25a. REC'D BY REGISTRAR
DEC 5 1967 | |
| 25b. REGISTRAR'S SIGNATURE
John J. Judge | | 25c. REGISTRAR'S ADDRESS
Powson, Towson, Md. 21204 | |

BALTIMORE

BALTIMORE

GREATER BALTIMORE MEI (ENTER 802 JAMSON RD)

ADOLPH

WEBER

MALE GEN

(RETIRED)

ADOLPH WEBER

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Dec 19 1947

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

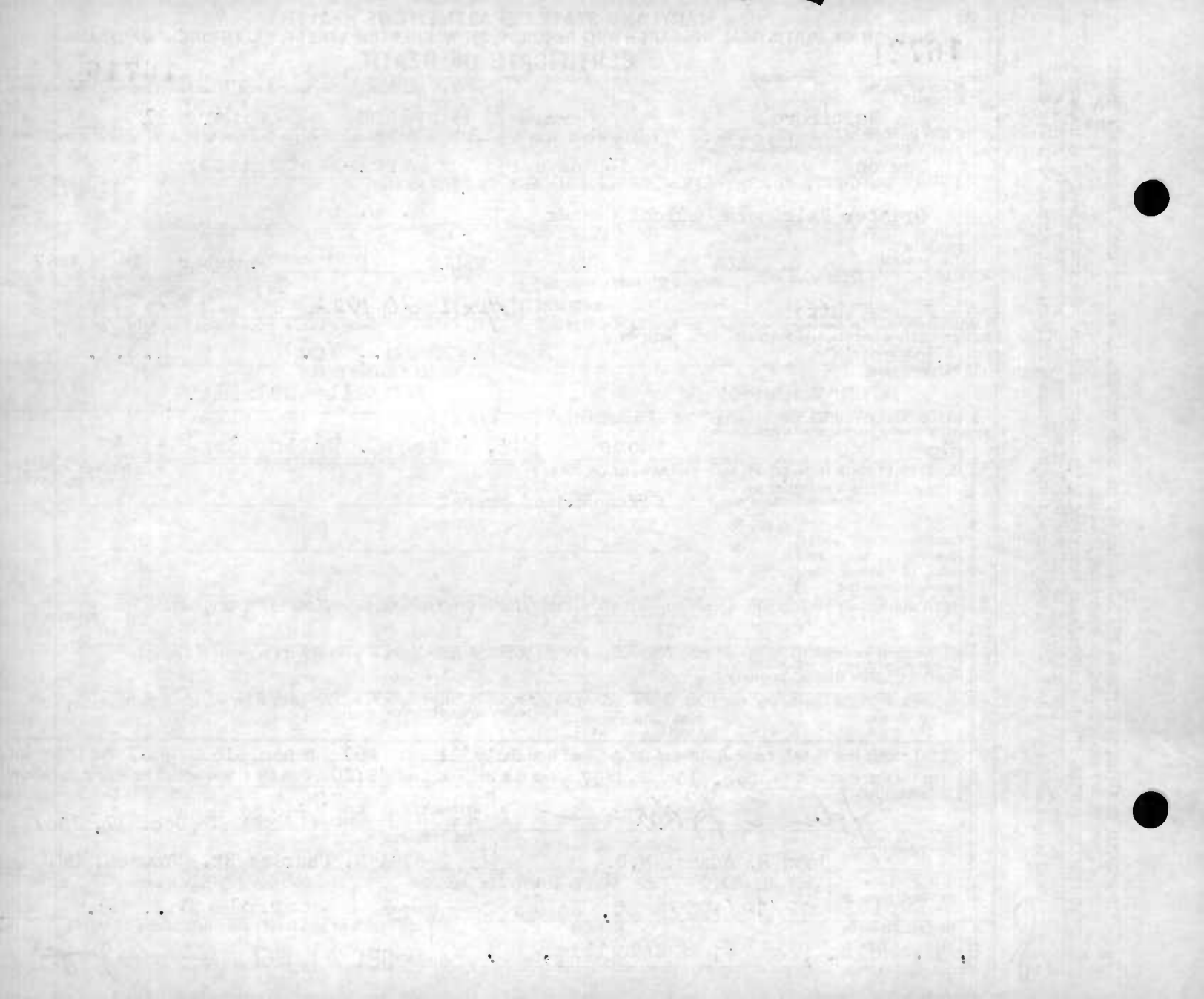
VR A15 (4)
20M 1/65

16721

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16716

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
140 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Greater Baltimore Medical Center | | e. STREET ADDRESS
R. D. 6 | |
| 3. NAME OF DECEASED (Type or print)
First
LOUELLA
Middle
NMN
Last
WELLS | | 4. DATE OF DEATH
Month
December
Day
16
Year
1967 | |
| 5. SEX
F | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
APRIL 20, 1922 |
| 9. AGE (In years last birthday)
45 yrs. | | 10. IF UNDER 1 YEAR
Months
Days
Hours
Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Bath Co., Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Sidney Maddox | | 14. MOTHER'S MAIDEN NAME
Louzella Brinkley | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mr. Jesse C. Wells | | Address
Same As #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of breast
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 31 , 19 67 , to Dec. 16 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 16 , 19 67 , and that death occurred at 9:20 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
John E. Adams | | 22b. DATE SIGNED
Dec. 17, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
John E. Adams, M.D. | | 22d. ADDRESS
6701 N. Charles St., Towson, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
12/19/1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. James Cemetery | | 23d. LOCATION (City, town or county) (State)
Carroll Co., Md. | |
| 24. FUNERAL DIRECTOR
C. M. Waltz | | 25a. REC'D BY REGISTRAR
DEC 21 1967 | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | c. LENGTH OF STAY IN lb
58 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rosewood State Hospital | | d. STREET ADDRESS
2110 Anna Avenue | |
| 3. NAME OF DECEASED (Type or print)
Paul Robin WEST | | 4. DATE OF DEATH
Month 12 Day 8 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4-3-54 |
| 9. AGE (In years lost birthday) yrs.
13 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dependent | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore City, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Howard Monroe West | | 14. MOTHER'S MAIDEN NAME
Elizabeth Ellen Carnes | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Rosewood State Hospital, Owings Mills, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
9217
IMMEDIATE CAUSE (a) Asphyxia (Bread in larynx)
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
23 min. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Severe mental retardation | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Choked on bread | |
| 20c. TIME OF INJURY Month, Day, Year
11:55 a.m. 12/8 1967 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
Holland Cottage | 20f. (City or town) (County) (State)
Owings Mills, Balto., Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE D. D. Caples | | 22. DATE SIGNED
12/8/67 | |
| EXAMINER'S NAME (Type) D. D. Caples, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) Reisterstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12/11/67 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Ullrich Funeral Home Dundalk, Md. | | 25a. REC'D BY REGISTRAR
DEC 13 1967 | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Jones</i> |

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| 16723 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 16718 | | | | | |
|---|--|----------------------------------|--|---|--|---|--|--|--|---|--|---|--|
| 1 | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TOWSON
c. LENGTH OF STAY IN 1b
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. JOSEPH HOSPITAL | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
-
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE
d. STREET ADDRESS
1013 BEAUMONT AVE. #21212
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
ALFRED
First Middle Last
WHITE | | | | 4. DATE OF DEATH
Month Day Year
DECEMBER 18 1967 | | | | | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
NEGRO | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
DECEMBER 24, 1922
44 yrs. | | 9. AGE (In years last birthday)
44 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SELF-EMPLOYED | | | | 10b. KIND OF BUSINESS OR INDUSTRY
ALF'S HAULING CO. | | 11. BIRTHPLACE (County & State, or foreign country)
Accomac Co., VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
GEORGE WHITE | | | | 14. MOTHER'S MAIDEN NAME
STELLA WHITE | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No. | | | | 16. SOCIAL SECURITY NO.
No. | | 17. INFORMANT
Mrs. Doris White | | Address
1013 Beaumont Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Encephalomalacia of brain stem
DUE TO
(b) thrombosis of basilar artery
DUE TO
(c) congenital aneurysm of basilar artery
7547
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that NO (this hospital) attended the deceased from DECEMBER 18, 1967 , to DECEMBER 18, 1967 that NO (we) last saw the deceased alive on DECEMBER 18, 1967 , and that death occurred at 11:05 PM from causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
Lawrence F. Misanik, M.D. | | | | 22b. DATE SIGNED
12/19/67 | | | | 22c. PHYSICIAN'S NAME (Type)
Lawrence F. Misanik, M.D. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE THEREOF
12-22-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Pleasant Rest Cem. | | 23d. LOCATION (City or Town) (County) (State)
Towson, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
MORTON & DYETT F.H. | | | | ADDRESS
1701 Laurens Street | | 25a. REC'D BY REGISTRAR
DEC 21 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16724

CERTIFICATE OF DEATH

16719

| | | | | | |
|--|----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u>
b. COUNTY <u>_____</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> 20-4 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Shangri La Nursing Home</u> | | | d. STREET ADDRESS
<u>11 S. Rosedale St.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) <u>Leo H. White</u>
First Middle Last | | | 4. DATE OF DEATH
<u>Dec. 10,</u> 19 <u>67</u>
Month Day Year | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9/10/18</u> | | 9. AGE (In years last birthday)
<u>49</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Violin Brothers</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Balto., Md.</u> | |
| 13. FATHER'S NAME
<u>Harry T. White</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>218-05-3858</u> | | 17. INFORMANT
<u>Mrs. Mary J. Young</u>
<u>11 S. Rosedale St.</u>
Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<u>350X</u> IMMEDIATE CAUSE (a) <u>Paralysis agitans</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) _____
DUE TO
(c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>40 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work _____ of work _____ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>40</u> , to <u>Dec 9,</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 9, 1967</u> , and that death occurred at _____ M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>Kennard Yaffe</u> | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>12/11/67</u> |
| 22c. PHYSICIAN'S NAME (Type)
<u>Kennard Yaffe</u> | | | 22d. ADDRESS
<u>5501 Forest Park Ave.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>12/12/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cem.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Witzke F. D. - 4101 Edmondson Av.</u> | | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 11 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> |

01131

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|----------------------------------|---|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 16725 | | | |
| 16720 | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN 1b
4 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | e. STREET ADDRESS
808 W. Lombard Street | |
| 3. NAME OF DECEASED
(Type or print) HENRY First Middle Last | | 4. DATE OF DEATH
Dec. 26 19 67 Month Day Year | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/7/87 |
| 9a. AGE (In years last birthday)
80 yrs. | | 9b. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machine Operator | | 10b. KIND OF BUSINESS OR INDUSTRY
Slipcover Factory | |
| 11. BIRTHPLACE (County & State, or foreign country)
Indiana | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes (If yes give war or dates of service) WW-1 | | 16. SOCIAL SECURITY NO.
216 16 69 05 | |
| 17. INFORMANT
Clinical Rcds, VA Hospital, Fort Howard Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO
(c) Unknown | | INTERVAL BETWEEN ONSET AND DEATH
Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
REMOTE LEFT MIDDLE CEREBRAL ARTERY THROMBOSIS | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from Dec. 22 , 19 67 , to Dec. 26 , 19 67 that (X) (we) last saw the deceased alive on Dec. 26 , 19 67 , and that death occurred at 9:55 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Neilson Neilson, M.D. | | 22b. DATE SIGNED
12/28/67 | |
| 22c. PHYSICIAN'S NAME (Type)
NEILSON NEILSON, M.D. | | 22d. ADDRESS
VA Hospital, Fort Howard, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
1/2/68 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
ZAMMINO FUNERAL HOME | | 25a. REC'D BY REGISTRAR
JAN 2 1968 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Jones | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

16726

MARYLAND DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16721

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD. b. COUNTY Balto. | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural - Towson | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Balto. | |
| c. LENGTH OF STAY IN 1b
37 days | | d. STREET ADDRESS
612 New Pittsburg Ave. | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Greater Baltimore Medical Center | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Frank Middle Everetts Last Williams | | 4. DATE OF DEATH
Month 12 Day 15 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-16-1907 |
| 9. AGE (In years last birthday)
60 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY
BETH-STEEL | |
| 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HENRY WILLIAMS | | 14. MOTHER'S MAIDEN NAME
ELLA BADGE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown)
(If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
218-03-1882 | |
| 17. INFORMANT
Mrs. D. Williams | | Address
612 New Pittsburg Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of lung
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/10 , 19 67 , to 12/15 , 1967, that (I) (we) last saw the deceased alive on 12/15 , 1967, and that death occurred at 7:25 M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
John E. Adams | | 22b. DATE SIGNED
12/16/67 | |
| 22c. PHYSICIAN'S NAME (Type)
John E. Adams, M.D. | | 22d. ADDRESS
6701 N. Charles Street | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12-21-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mount Auburn Cem. | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
MORTIMER D. HOFFMAN | | 25a. REC'D BY REGISTRAR
DEC 19 1967 | |
| ADDRESS
1000 E. Pratt St. | | 25b. REGISTRAR'S SIGNATURE
James J. Judge | |

BAH

9-12-1907

W. J. Williams for W. J. Williams

John E. Adams

DEC 1 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1
30M REV. 17-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|--|--|---|----------------------|--|--------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Ora S. Williams | | | | | 2a. DATE OF DEATH
Month Dec. Day 29 Year 1967 | | | 2b. HOUR
M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Oct. 14, 1897 | | | 6. AGE (In years lost birthday)
70 YRS. | | IF UNDER 1 YEAR
MONTHS
IF UNDER 24 HRS.
DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
XX Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Balto. Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rosedale | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
2322 Hamiltowne Circle | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Salesclerk | | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Rosedale | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
2322 Hamiltowne Circle | | |
| 14. FATHER'S NAME
First Lawrence Middle Anderson Last Anderson | | | 15. MOTHER'S MAIDEN NAME
First Cora Middle Edwards Last Edwards | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Richard Novak, 2322 Hamiltowne Circle | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma, Gall Bladder
1551
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 12/29/67 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
John G. Orth, M.D. DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
12/30/67 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
G. Truman Schwab | | | | | 22e. ADDRESS
8019 Philadelphia Rd. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 2, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore County, Maryland | | | | |
| 24. FUNERAL DIRECTOR
G. Truman Schwab, 3512 Frederick Ave., Baltimore Maryland, 21228 | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 2 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------------------|--------------------|---|--|---|--|--|--------------------|-----------------------------------|--|--|--|--|--|---|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
BALTIMORE
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
BALTIMORE
c. LENGTH OF STAY IN b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
7903 BROOKHAVEN ROAD | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
BALTIMORE
d. STREET ADDRESS
7903 BROOKHAVEN RD
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
FRANCES | | | First
D. | | | Middle
WILLNER | | | Last
DEC | | | 4. DATE OF DEATH
Month
DEC
Day
15
Year
1967 | | | | | | | | | | | |
| 5. SEX
F | | 6. COLOR OR RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
DEC 3, 1912 | | 9. AGE (In years last birthday)
55 yrs. | | IF UNDER 1 YEAR
Months
Days | | IF UNDER 24 HRS.
Hours
Min. | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CLERK | | | | 10b. KIND OF BUSINESS OR INDUSTRY
SOCIAL SECURITY | | | | 11. BIRTHPLACE (County & State, or foreign country)
NEW YORK | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | | | | | |
| 13. FATHER'S NAME
JOSEPH | | | | | | 14. MOTHER'S MAIDEN NAME
NETTIE | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
— | | | | 17. INFORMANT
SAMUEL H. WILLNER | | | | Address
SAME | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Wide spread metastases
163X DUE TO Carcinoma of Lung
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
INTERVAL BETWEEN ONSET AND DEATH
April 67
Jan 67 | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (the hospital) attended the deceased from Jan 1967 to Dec 15, 1967 , that (I) (we) last saw the deceased alive on Dec 15 4 PM 19 67 , and that death occurred at 4 PM from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
E.T. Lisansky M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS
6804 PKHS Ave (15) | | | | | | 22b. DATE SIGNED
Dec 16/67 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE THEREOF
12/18/1967 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Hope | | | | 23d. LOCATION (City, town or county) (State)
York New York | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Sylvan S. Lewis & Son, INC. | | | | | | ADDRESS
Garrison, Maryland | | | | | | 25e. REC'D BY REGISTRAR
DEC 19 1967 | | | | 25b. REGISTRAR'S SIGNATURE
John Charles Judge | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS 14
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16723
16724
CERTIFICATE OF DEATH

| | | | |
|--|----------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore
c. LENGTH OF STAY IN 1b 9 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 125 Dumbarton Road #21212
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last
EVELYN ANGELINE WILSON | | 4. DATE OF DEATH Month Day Year
12 27 19 67 | |
| 5. SEX F | 6. COLOR OR RACE CAU | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 07-10-01
9. AGE (In years last birthday) 66
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY -----
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME Robert DeHuff | | 14. MOTHER'S MAIDEN NAME ROSE Drane | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 216-38-1418
17. INFORMANT Mrs. Paul C. Botwin, Glenarm, Md.
Patient's History | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 170X <u>cachectia</u>
DUE TO (b) <u>generalized Metastatic carcinoma</u>
DUE TO (c) <u>carcinoma of breast</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-18, 1967, to 12-27, 1967, that (I) (we) last saw the deceased alive on 9-20 AM 12-19-67, and that death occurred at 2:40 AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Dr. G. Maghami</u> | | 22b. DATE SIGNED 12/27/67
M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) _____ | | 22d. ADDRESS 125 Dumbarton RD; | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/29/67
23c. NAME OF CEMETERY OR CREMATORY Parkwood
23d. LOCATION (City or town) (County) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Rd.
Balto., Md. 21212 | | 25a. REC'D BY REGISTRAR JAN 3 1968
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
25M 1/67

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | |
|--|----------------------------------|---|--|---|---|
| 16730 Item #2d Film #G396 12/20/67 | | | 16725 | | |
| CERTIFICATE OF DEATH | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Codd Convalescent Home</u> | | | d. STREET ADDRESS
<u>17 Florida Avenue</u>
<u>Codd Convalescent Home</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
Type or print <u>Georgia F. Wilson</u> | | | 4. DATE OF DEATH
Month <u>December</u> Day <u>4</u> Year <u>1967</u> | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 20, 1879</u> | | 9. AGE (In years last birthday) yrs. <u>88</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | |
| 13. FATHER'S NAME
<u>Arthur Flather</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Francis Shipley</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Family records</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
DUE TO (b) <u>Atherosclerotic Cardio-renal</u>
DUE TO (c) <u>Vascular Disease</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 hrs</u>
<u>10 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/1, 1966</u> to <u>12/4, 1967</u> that (I) <u>did</u> saw the deceased alive on <u>19</u> , and that death occurred at <u>11</u> M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>Charles F. Donald</u> | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type)
<u>Charles F. Donald</u> |
| 22d. ADDRESS | | | 22e. REC'D BY REGISTRAR
DATE <u>DEC 11 1967</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Dec. 7, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Ft. Lincoln Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Washington, D.C.</u> |
| 24. FUNERAL DIRECTOR
<u>John Burns' Sons, Towson, Maryland</u> | | | 25a. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

1912

DEPARTMENT OF COMMERCE

UNITED STATES



LIBRARY

U.S. DEPT. OF COMMERCE

16731

CERTIFICATE OF DEATH

16726

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Keisterstown</u> | | c. LENGTH OF STAY IN TB
<u>4 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Keisterstown</u> | | 03.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>102 Chestnut Hill Lane</u> | | | | d. STREET ADDRESS
<u>102 Chestnut Hill Lane</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>DREXEL</u> Middle <u>N.M.N.</u> Last <u>WINNER</u> | | | | 4. DATE OF DEATH
Month <u>December</u> Day <u>24</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>February 9 1908</u> | |
| 9. AGE (In years last birthday)
<u>59</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Social Security</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Social Security</u> | | 11. BIRTHPLACE (Country & State, or foreign country)
<u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Anthony Joseph Drexel Winner</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Helen Flora Roberts</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>203-28-6800</u> | | 17. INFORMANT
<u>Anne M.W. Winner</u> | | Address
<u>102 Chestnut Hill Lane</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma - lung - left</u>
163X
Conditions, if any, which gave rise to immediate cause }
(a), stating the underlying cause last. }
DUE TO (b)
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>8 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u> </u> p.m. <u> </u>
19 <u> </u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 1967</u> to <u>December 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>December 20, 1967</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Clarence E. McWilliams</u> | | | | 22b. DATE SIGNED
<u>12-24-67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. Clarence E. McWilliams</u> | | | | 22d. ADDRESS
<u>11904 Keisterstown Rd. Keisterstown Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>XXXXXX</u> | | 23b. DATE THEREOF
<u>12/26/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Johns Hop. School of Med.</u> | | 23d. LOCATION (City, town or county) (State)
<u>709 N. Wolfe St., Balto.</u> | |
| 24 FUNERAL DIRECTOR'S SIGNATURE | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 29 1967</u> | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

16732

16728

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson
c. LENGTH OF STAY IN 1b
Maryland | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
BALTO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21212
d. STREET ADDRESS
241 Rodgers Forge Rd. | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
William Mitchel WOZNIAK | | 4. DATE OF DEATH
Month Day Year
December 20, 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 31, 1914 |
| 9. AGE (In years lost birthday) yrs.
53 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Real Estate | |
| 11. BIRTHPLACE (County & State, or foreign country)
Massachusetts | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
V.M. Wozniak | | 14. MOTHER'S MAIDEN NAME
Ladislai STULPIN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
yes- peacetime | | 16. SOCIAL SECURITY NO.
026-10 8733 | |
| 17. INFORMANT
Beverly J. Wozniak | | Address
241 Rogers Forge Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
331X IMMEDIATE CAUSE (a) Cerebral hemorrhage
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
INTERVAL BETWEEN ONSET AND DEATH _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/16/ , 19 67 , to 12/20/ , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/20/ , 19 67 , and that death occurred on 12/20/ , 19 67 , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Jaime Singzon</i> | | 22b. DATE SIGNED
12/20/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Jaime Singzon, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12/23/67 | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Mem. Grds. | 23d. LOCATION (City or Town) (County) (State)
Balto. County Md. |
| 24. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home | | 25a. REC'D BY REGISTRAR
DATE DEC 29 1967 | |
| ADDRESS
6500 York Rd. | | 25b. REGISTRAR'S SIGNATURE
<i>James Judge</i> | |
| Balto., Md. 21212 | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| | | | | | | | |
|---|--|--|--|---|--|--|---------------------------------------|
| 16733 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | Item # 22b File # 396 12/28/67 km | | 16727 | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
PORT HOWARD
c. LENGTH OF STAY IN 1b
35 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
EDGEWATER
d. STREET ADDRESS
02.2
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First CHARLES
Middle LEO
Last WITT | | 4. DATE OF DEATH
Month DECEMBER
Day 15
Year 19 67 | | 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
9 23 15 | | 9. AGE (In years last birthday) yrs.
52 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
SHADYSIDE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CHARLES F. WITT | | | | 14. MOTHER'S MAIDEN NAME
MARTHA R. TROTT | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW-11 | | 16. SOCIAL SECURITY NO.
220 16 5114 | | 17. INFORMANT
CLIN. REC., VAH, FT. HOWARD, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GANGRENE OF BOWELS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) MESENTERIC EMBOLISM
DUE TO
(c) EMBOLISM
GENERALIZED ARTERIOSCLEROSIS AND THROMBO- | | | | INTERVAL BETWEEN ONSET AND DEATH
DAYS
MONTHS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 0 a.m.
p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 10 1967 , to Dec. 15, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 15, 1967 , and that death occurred at 3:45 p.m. from causes and on the date stated above. | | | | | | | 22a. SIGNATURE
George Dudas |
| 22c. PHYSICIAN'S NAME (Type)
GEORGE DUDAS, MD | | 22d. ADDRESS
VAH, PORT HOWARD, MARYLAND | | 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
12 16 67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12-18-67 | | 23c. NAME OF CEMETERY OR CREMATORY
CHRIST CHURCH CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
OWENSVILLE, MARYLAND | |
| 24. FUNERAL DIRECTOR
W Harry Hutchins | | 24b. ADDRESS
Hutchins Funeral Home
Owings, Md. | | 25a. REC'D BY REGISTRAR
DEC 20 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1975

10721

DEPARTMENT OF DEFENSE

NAME AKA/ALIAS

MARYLAND

DATE OF BIRTH

REGISTERED

32 DAYS

PORT HAWARD

VETERANS ADMINISTRATION HOSPITAL

07

15

DECEMBER

WITT

LEO

CHARLES

22

9 22 12

X

WHITE

MALE

U.S.A.

SHADYSIDE, MARYLAND

MARTHA R. TROTT

CHARLES E. WITT

320 16 214 CLIN. REC., VAN, PT. HOWARD, MARYLAND

WW-11

YES

CANNING ON POWERS

RESISTANT TO BOLLING

DAYS

MONTHS

RESISTANT

GENERALIZED ASTHENOCLASIS AND THROMBO-

X

Dec. 12 67

67

Nov. 10

67

Dec. 12

3:45 p.

12 16 67

X

VAN, PORT HOWARD, MARYLAND

GEORGE DUDAS, MD

CHRIST CHURCH CEMETERY, OAKVILLE, MARYLAND

Hutchins Funeral Home

Croft, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 16734 | | | |
| 16729 | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21212 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Josephs Hospital | | d. STREET ADDRESS
5815 Glenkirk Court | |
| 3. NAME OF DECEASED
(Type or print)
Perdue | | 4. DATE OF DEATH
December 30 1967 | |
| 5. SEX
male | | 6. COLOR OR RACE
white | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6 2-28-07 | |
| 9. AGE (In years lost birthday)
60 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired U.S. Army | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Iowa | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
? Wymore | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
Yes 29 Years | | 16. SOCIAL SECURITY NO.
216-34-6887 | |
| 17. INFORMANT
Mrs. Olivia Wymore | | Address
(Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
154 X IMMEDIATE CAUSE (a) generalized carcinomatosis of abdomen
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) carcinoma of rectum
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from December 29, 1967 to December 30, 1967 , that (I) (we) last saw the deceased alive on December 30, 1967 , and that death occurred at 5:20 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Freidoon Malek | | 22b. DATE SIGNED
12-30-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Freidoon Malek | | 22d. ADDRESS
7620 York Road, Baltimore 21204 Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
1/4/68. | |
| 23c. NAME OF CEMETERY OR CREMATORY
Balto. National Cem. | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR
DATE JAN 2 1968 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

1875

RECEIVED

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cleared by sep. ped. ex. dr. um A. Callahan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| | | | | | |
|--|--|---|--------------------------------------|--|--|
| Item 188, film #395
12-12-67 mt
16735 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 16730 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>Balt</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cockeysville</u> | | c. LENGTH OF STAY IN 1b
<u>5 yrs 10 mo</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Bonnie Blunt Masonic Homes</u> | | | | d. STREET ADDRESS
<u>6815 Everall Ave</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Daisy</u> Middle <u>E.</u> Last <u>Yingling</u> | | 4. DATE OF DEATH
Month <u>12</u> Day <u>1</u> Year <u>1967</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2-10-1878</u> | 9. AGE (In years lost birthday)
<u>89</u> yrs. | IF UNDER 1 YEAR
Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Baltimore md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | |
| 13. FATHER'S NAME
<u>William Harber</u> | | 14. MOTHER'S MAIDEN NAME
<u>Christina Spies</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>215-01-2873 B</u> | | 17. INFORMANT
Address <u>Same as</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>
DUE TO <u>recurrent</u>
(b) <u>Advanced senility</u>
DUE TO <u>Fractured hip</u>
(c) <u>June 1967</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>August 1965</u> to <u>Nov 30, 1967</u> that (I) (we) last saw the deceased alive on <u>Nov 30, 1967</u> , and that death occurred at <u>1:30 PM</u> , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>JAMES H. HAMED MD.</u> | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>12/1/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JAMES H. HAMED</u> | | 22d. ADDRESS
<u>MASONIC HOME, Cockeysville, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>Dec 4, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Landon Park Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>Wm. Cook Brooks Towson</u> | | ADDRESS
<u>1050 York Rd Towson Md</u> | | 25a. REC'D BY REGISTRAR
<u>DEC 5 1967</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | |

1013

1013

1013



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16736

16731

Reg. Dist. No.

FOR STATE HEALTH DEPT.

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> 21222 b. COUNTY <u>BALTIMORE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>DUNDALK</u> | | c. LENGTH OF STAY IN 1b
<u>7 YRS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>DUNDALK</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>1973 SNYDER AVE</u> | | | | d. STREET ADDRESS
<u>1973 SNYDER AVE.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>LEONA SCHAEFER YOUNG</u> | | | | 4. DATE OF DEATH Month Day Year
<u>12/28/67</u> 19 | | | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>OCT. 28, 1897</u> | | 9. AGE (In years last birthday) <u>70</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>SEAMSTRESS</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>TAILORING</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>JOSEPH SCHAEFER</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MADELINE WAGNER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>216-10-7542</u> | | 17. INFORMANT Address
<u>CAROLINE D. LETTS AS IN #2 ABOVE</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>A-S-C-V-Disease</u>
<u>4221</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>NONE</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>M B DAVIS</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>HELYN B. DAVIS M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6800 MORNINGTON RD 21222</u> | | | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>12/30/67</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>HOLY REDEEMER</u> | | 22d. LOCATION (City, town, or county) (State)
<u>BALTIMORE, MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W. B. DAVIS</u> | | | | 24a. REC'D BY REGISTRAR
<u>DEC 29 1967</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Charles Yager</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10131
DEATH



STATE OF NEW YORK
COUNTY OF [illegible]

[Faint, mostly illegible text in the upper section of the form, likely containing personal information and details of the death.]

[Faint, mostly illegible text in the middle section of the form, likely containing medical history and cause of death.]

[Faint, mostly illegible text in the lower section of the form, likely containing a certificate of death and signature lines.]

[Vertical text on the right margin, possibly a filing stamp or reference number.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16732

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson 4 | | c. LENGTH OF STAY IN 1b
21218 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Charles Zimmerman | | 4. DATE OF DEATH December 23, 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 20, 1902 |
| 9. AGE (In years last birthday) 65 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Field Engineer | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
usa | |
| 13. FATHER'S NAME
Charles Zimmerman | | 14. MOTHER'S MAIDEN NAME
Effie Mae Baston | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) None | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Florence P. Zimmerman same address | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of rectum with metastases to liver
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. }
DUE TO (b) _____
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (X) (this hospital) attended the deceased from December 21, 1967 , to December 23, 1967 , that (X) (we) last saw the deceased alive on December 23, 1967 , and that death occurred at 8:10AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Eduardo Montelibano</i> | | 22b. DATE SIGNED
December 23, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Eduardo Montelibano, M. D. | | 22d. ADDRESS
7620 York Road, Towson 4 M. D. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
12/26/67 | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | 23d. LOCATION (City or Town) (County) (State)
Woodlawn, Md. |
| 24. FUNERAL DIRECTOR
<i>Wm. J. Tishman & Sons</i> | | 25a. REC'D BY REGISTRAR
DEC 27 1967 | |
| ADDRESS
<i>Baltimore, Md.</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

0 1000 2000 3000 4000 5000 6000 7000 8000 9000 10000